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INDEX TO VOLUME XXVII.

	PAGE.
Abortion	642
Abortion, "Missed."	939
Abortion, Tent Forced into Douglas' Cul-de-Sac	780
Abortion, Habitual, Assafœtida in	946
Abscess, Retro-Pharyngeal, in Infancy	696
Abscesses, Artificial, to Cure Sepsis	677
Abscesses, Pepsin for	975
Address to Alumni Maryland University	604
Address to College Physicians and Surgeons	1123
Address to Graduating Nurses	732
Adhesive Straps in Chest Disease	1088
Advances, Medical, in Maryland	609
Albuminuria in Relation to Surgical Operations	738
Alcohol, Evils of Tippling	682
Alice Mitchell Case	1109
Alopecia Areata, Treatment	1099
Altitude, Effects of	1043
Anæmia due to Pulmonary Atelectasis	767
Anarchist, The Medical	952
Anderson, Edward, M. D	1053
Aneurysm of Aortic Arch	731
Aneurysm, Thoracic	1073
Antifebrin Poisoning	1108
Aphasia	639
Army Medical Examinations	1001
Arterio Sclerosis	828
Ashton, Wm. Easterly, M. D	773
Asparagus Stimulates Glycosuria	857
Asphyxia from Illuminating Gas	947
Association, American Medical, Officers	850
Asthma, Treatment	1092
Asthma from Rectal Trouble	852
Atrophied Faculties	629
Atropine, Unusual Action of	942
Baby, Seaside or Mountain for	1063
Bacilli, Intestinal	1134
Bacteria; What They Do	1046
Baltimore, Reform Needed in	586
Baltimore, Water Supply of	781
Barefoot, Healthfulness of	899
Barker, J. Ridgway, M. D	644
Barton, J. M., M. D	801
Battery, Chloride of Silver	693
Belt, E. Oliver, M. D	771
Bicyclists, Catarrhal Laryngitis of	768
Bismuth Obstructs Bowels	703
"Black Death," The	1138
Bladder, Chronic Catarrh, Eucalyptol	1119
Bladder, Hairpin in	692
Bladder, Supra-pubic Aspiration of	647
Bladder, Disease of, Simulating Prostatitis	790
Bladder, Tuberculosis and Calculus of	789
Blindness, Report of Committee on Prevention of	713
Blood, New Way to Examine	768
Blood, White Corpuscles Protect	1097
Bond, A. K., M. D	819, 903, 1081
Bone, New Formation of	1051
Bordley, James, M. D	913
Bowel, Lateral Anastomosis of	773
Brain, Abscess of, Recovery	863
Brain Action, Stimulation by Posture	834
Brain, Bruises of	853
Breast, Relation between Cancer and Inflammation of	831
Breast, Duct Papilloma of	878
Bressler, F. C., M. D	731
Browne, B. B., M. D	972, 974, 1079
Buckler, Article by Dr	586
Buckler, Thomas H., Sr., M. D	575
Buffalo, Health Department of	591
Burns, Glycerine in	616
Bursæ, Hæmorrhage into	1027
Cæsarean Section	1015
Camphoid, Substitute for Collodion	768
Canadian Physicians and Health Reports	699
Cancer of Stomach	1097
Cancer, Treatment	676
Cancer of Chimney Sweeps	1008
Cantharides, Blistering by Living	1112
Carlsbad	653
Carotid Artery Ligated After Tonsillotomy	699
Cathell, Wm. T. C., M. D	925
Catheter, The Ureteral	741
Cerebral Surgery	1007
Chancres of Finger, Which Glands Enlarge	721
Character, The Test of	896
Character, the Test of a Physician	881
Chew, Samuel C., M. D	732
Chicago Health Laws	763
Child, Training the Unborn	587
Children's Country Home	781
Children's Fresh Air Society	715
Chloroform, Syncope, and Massage of the Heart	784
Chloroform, Strychnine to Prevent Poisoning	780
Chloroform, Dangers of	1052
Cholera, Treatment of	988
Cholera, Treatment in 1832	1047
Cholera Among Sharks	601
Cholera, Diagnosis of	1083
Cholera, Curious Remedies for	1077
Cholera, Ramblings of	1072
Cholera Wards, Visit to Hospital Necker	1157
Chorea of Pregnancy	943
Chronicle, Our Weekly...1068, 1085, 1110	1133
Club Foot, Weight of Body in	1035
Cocainism, A Case of	965
College, Clinical and Specialty Hospital, Chicago	872
Colon, Congenital Contraction of	1009
Congress, First International, for Gynæcology and Obstetrics	1131
Congress, International, at Brussels	1103
Constipation, Neurotic	678
Constipation, Treatment of	702
Constipation, New Remedies for	983
Convulsions, Treatment of	1006
Convulsions After Scarlatina	1081
"Co-operation," not "Competition."	976
Copyright, Newspaper	1026
Cordell, Eugene F., M. D	604, 683, 914

4708

PAGE.

Cornea, Ulcers of, After Gonorrhœa..... 771
Coryza, Snuff for. 1120
Coto for Diarrhœa..... 1075
Couch, The 658
Craniectomy, Linear 896
Craniectomy, Linear..... 843
Croup Following Influenza..... 736
Croup, Primary Laryngeal..... 855
Crowe, Stephen, M. D..... 1013
Crutchfield, Eugene L., M.D..... 1064
Culture in Medicine 1087
Cyanosis, Case of, in Infant 592
Cyst, Dermoid, Containing a Heart.. .. 1134
Cyst, Dermoid, in a Child..... 1118
Deaf-Mutism, Acquired..... 805
Decay and Death, Meaning of 960
Delirium Tremens 958
Dermatology, Remedy in..... 1098
Diabetic Coma, Diagnosis..... 941
Diabetics, Amputation in 941
Diaphragm, Paralysis of..... 783
Diarrhœa, Antimony and Coto for..... 1075
Diphtheria, Treatment of..... 807
Disease-Germs, Variability of 943
Disinfection by Steam 683, 914
Dislocation of Elbow Joint..... 1094
Dispensary Abuse in London..... 932
Diuretic Drugs 1005
Diuretics, Lactose and Glucose as. 770
Diuretin..... 922
Diuretin in Children 651
Doctor, The Ready 716
Drowning, New Way to Revive in 921
Duboisinum Sulphate in Insanity..... 748
Dysentery, Rectal Injections in.. 809
Dysmenorrhœa, Cervical..... 737
Dysmenorrhœa, Galvanism for..... 812
Ear, Lead in, Removed by Mercury 718
Ear, Nature of Polypi of..... 788
Ear, Opening of Mastoid Process 620
Eclampsia, Therapy of 833
Eclampsia and Septicemia..... 978
Ectropion of Both Eyes..... 1018
Eczema in Infants..... 961
Egg-Water, Formula for 714
Eirley, Clara S..... 972
Elbow-Fracture, Treatment for Stiffness. 698
Electric Bath, Miscarriage from 989
Electric Currents and Seed Growth..... 635
Electric Current, Poisoning by Testing with Mouth 737
Electric Douche 722
Electricity in Nervous Diseases 688
Electricity in Catheterization. 819
Electrocution in New York 1001
El Paso as a Health Resort 949
Emetic, Death After..... 1072
Enema, Best Nutritive..... 765
Enterectomy for Obstructive Epithelioma 801
Epidemics, Limitations of 1119
Epilepsy, Diet and Exercise in..... 667
Epileptics, Legislation for, in New York. 955
Epistaxis 1141
Epithelial Pearls in Children..... 1095
Erysipelas, Abortive Treatment of..... 951
Ether, Influence on Women 909
Eucalyptus Honey for Phthisis 812
Exercise, Reasons for 899
Eye, Electro-Magnet Removes Steel from 779
Faculty, Med. and Chirurg., of Maryland 610

PAGE.

Faculty, Med. and Chirurg.,of Maryland, Sections of..... 695
Faculty, Med. and Chirurg., of Maryland, Officers of..... 594
Faculty, Med. and Chirurg.,of Maryland, Semi-Annual Meeting..... 1132
Fads, Protective Influence of 674
Faces, White. 673
Fatty Deposit, A Case of..... 680
Fendler, Amelia M..... 974
Femur, Diastasis Through Neck of..... 986
Fever, African..... 1011
Fever, African, Causes of 787
Fever, Enteric, Cause of.....763, 1049
Fever, Typhoid, Plea for Brand Method in Private Practice..... 1115
Fever, Typhoid, Perchloride of Iron in.. 924
Fever, Typhoid, Relapse of..... 855
Fever, Typhoid, Tympanites in..... 917
Fever, Typhoid, in Ireland 1003
Fever, Typhoid, in Nebraska 1050
Fever, Typhoid, in Rockville..... 1053
Fever, Typhus, Ætiology of..... 945
Fevers, Treatment of..... 856
Flatulence, Cure for 975
Flint Club..... 1121
Flour, Burnt, for Erysipelas and Burns.. 672
Foreign Body in Air Passages..... 931
Fort, Samuel J., M. D 667, 1057
Fraternal Relations between "Practitioners" and "Specialists." 1101
Friedenwald, Harry, M. D 620
Friedenwald, Julius, M. D..... 820
Gall-Stone, Expulsion of..... 906
Galvanism in Dysmenorrhœa 812
Galvanism for Fibroids..... 1094
Ganglion and Tendon Sheath Inflammation 717
Gardner, Wm. S., M.D. 573, 929, 998. 1015, 1103, 1131
Gas-Poisoning 947
Gastralgia, Electricity in 982
Gastritis, Resorcin in..... 712
Gavage in Paris 1077
Gestation, Ectopic..... 917
Glycosuria Simulated by Asparagus..... 857
Goitre, Strophanthus for..... 1033
Gonococci in the Blood. 965
Gonorrhœa in Babies..... 1076
Gonorrhœal Rheumatism, Joint Stiffness 675
Goodell's "Golden Gems."..... 876
Gout, Mineral Waters for..... 920
Gravel, Uric Acid, Prevention of..... 830
Greely, G. H., M. D..... 758
Hæmorrhage After Enucleation of Eye.. 1054
Hæmorrhage of Eye, Smell and Taste Restored .....'..... 1032
Hæmorrhoids, Calomel Locally for. ... 769
Hann, Laura Cook..... 1079
Hay Fever, Treatment..... 872
Health Board of New York..... 824
Health Force, Keep it Pure..... 1066
Health Resort, El Paso as a 949
Heart-Clot in Pneumonia..... 1030
Heart Disease and Anæsthesia..... 644
Heat-Stroke in Children..... 761
Hereditary Transmissions of Mutilations 874
Heredity, a Study of its Dark Side..... 907
Heredity of Defective Fingers 612
Hernia Institute of Baltimore 902

PAGE.

Hernia of Abdominal Cicatrix After Laparotomy 1139
Hernia, Omental, of Umbilicus 972
Hernia, Radical Cure in Children 1006
Hernia, Scientific Cure for 602
Hernia Simulated by Gland Abscess 634
Herpes, Varicella and 1092
Hiccough, Cupping in 724
Hiccough, Nerve-Compression for 631
Homatropine, Unusual Action of 942
Horse, Balky, How to Treat 769
Hurd, Henry M., M. D 661
Hydrogen Peroxide, Use of 899
Hypnotism 916, 955
Hypnotism, German Professor on 828
Hysteria, Underlying Cause of 714, 940
Iddings, C. E, M. D 1101
Imbecile, What Shall be Done with the 1057
Immunity, Acquired 613
Inebriety, Treatment of 871
Infancy, Retropharyngeal Abscess in 696
Inflammation, Dr. Leber on 1028
Influenza 575
Influenza, Narceine for 722
Influenza Followed by Croup 736
Influenza and Pregnancy 832
Injections of Gland Matters 747
Insane, Pelvic Diseases of 1078
Insanity, Post-Febrile 661
Insanity, Puerperal 876, 980, 1018
Insomnia in Infants 745, 938
Insomnia Treatment 1138
Intestinal Obstruction 991
Intestine, Gangrene of the, Spontaneous Recovery 700
Intestine, Nerve-Endings of 786
Inversion of Body in Labor 1031
"Ions" in Salt Solutions 1085
Iron, Perchloride, in Typhoid Fever 924
Iron Salts in Diarrhœa 1095
Italian Malaria 985
Japan, Medicine in 832
Jaundice, Cause of 677
Jaundice, Obstructive 936, 1116
Jaw, Operation for Recurrent Dislocation 701
Johnson, James T., M. D 947
Journal Clubs 652
Judson A. B., M. D 1035
Kennedy, J. H., M. D 642
King, John T., M. D 639
Labor, Difficult, Inversion in 1031
Labor, Difficult, Uterus Bicornis 573
Lacrymal Gland, Hernia of 740
Lacrymal Gland, Symmetrical Inflammation of 923
Lacrymal Puncta 785
Laparotomy for Retroflexion 1079
Laparotomy to Remove Ovaries 974
Laryngeal Paralysis in Infants 1114
Laryngectomy, Case of 815
Laryngology, Review of, for Year 793
Larynx, Artificial 1011
Law, Maryland Medical, Arrest Under 765
Law, Medical Comments on 675, 825, 869
Leeches, Death from 889
Leopold's Clinic, Notes from 929, 1015
Leprosy, Identity of Syringo-Myelitis and 1137
Leprosy in Russia 915
Lettuce 585
Leucocytes as Protectors 1097

PAGE.

Leukæmia 584
Life Assurance, Early Provident Scheme 1066
Lily of the Valley, Therapy of 743
Long, J. W., M. D 881
Malaria in Italy 985
Malnutrition in Childhood 614
Mamma, Phases of Growth 937
Man More than a Simple Organism 811
Martenet, J. Fussell, M. D 991
Maryland, Future of 803
Massage (Mallaise) in India 1091
Massage of Heart 784
Mastitis, Tuberculous 1024
Measles, Bacillus of 676
"Medical Examiners" Act 913
Medical Examining Board, Maryland 1002
Medical Reforms, Interviewing Candidates About 911
Meningitis in Children 749
Mercury to Remove Impacted Lead 718
Merrick, S. K., M. D 793, 969
Methyl-Blue 1032
Metrorrhagia, Treatment of 871
Microscope, Which Shall I Buy? 827
Midwifery in India 1074
Mineral Waters for the Gouty 920
Montreal Hospital, First 984
Morphia Poisoning, Recovery 769
Morphine in Gynæcology 617
Morrison, Wm. H., M. D 843, 863
Morton, Thomas S. K, M. D 859
Mosquito, Driven Away by Oil of Cloves.
Mouth, Epithelial Pearls in 1095
Mouth, To Keep Sweet 1090
Narceine in Influenza 722
Nasal Disease, Relation of Surgery to 727
Neale, L. E., M. D 595, 1123
Nebraska Typhoid 1051
Nephritis, Nitro-Glycerine for 986
Nerves, Optico-Ciliary, Resection of 829
Neuralgia, Hypogastric 627
Neuralgia, Pyorrhœa Alveolaris Mistaken for 590
Neurasthenia 758
Neuritis, Treatment of 633
Nitroglycerine, Therapy of 1141
Nurses, Graduates Maryland University 636
Obstetrical Case, Normal, Treatment of 929
Obstetrics, Chloroform, Ergot and the Douche 595
O'Donovan, Charles, M. D 749
Œsophagus, Stricture Cured 802
Opium-Eating in India 1120
Opium Habit in Infant, Congenital 612
Opium Habit, Treatment 804
Opium-Poisoning, Emetic in 628
"Orificial" Fad 1023
Osteo-Myelitis, Obscure Case of 606
Ovariotomy in Pregnancy 966
Ovariotomy, Peritoneal Adhesions after 1117
Oxygen Inhalations 764
Pain, Periodical Intermenstrual 1136
Paraldehyde in Insanity 719
Paralysis, Treatment by Injections of Brains 770
Paralysis, General, Points About 851
Paralysis, General, of Insane, Surgery of 919
Paralytics, General, Self-Mutilation of 943
Pastoral Scene 742
Pelvic Suppuration 1103

PAGE.
Pericarditis, Idiopathic....649, 969
Perineum, Injuries to. 846
Peristalsis from Crystal of Sodium Carbonate. 769
Peritonitis, Septic, After Abortion.... 1013
Pertussis, Photophobia in.... 988
Pessary, Retained and Bridged.... 1012
Phenyl Hydrazin Test 1093
Phlegmasia Dolens Following Influenza. 724
Physician, The True 593
Pineal Gland, Tumor of 939
Placenta Prævia.... 1107
Placenta Prævia, Treatment of, in Paris. 766
Pleuritic Effusion, Sodium Salicylate in. 616
Pleuritic Effusion, Treatment.... 767
Pneumonia Aborted by Digitalis.... 854
Pneumonia, Acute, Nature and Sequel.. 935
Pneumonia, Effect on Kidneys.... 764
Polypi of Ear, Nature of.... 788
Pott's Disease and Pregnancy.... 675
Pregnancy, Point in Diagnosis.... 613
Prescribing, Caution in.... 827
Preston, George J., M. D.... 688
"Probus." 907
Pronunciation of Medical Terms....1064, 1067
Prostate up to Date.... 734
Prostatic Hypertrophy, Electricity in... 1141
Prostatitis, Simulation of 790
Puerperal Peritonitis 1089
Rats as Disease Breeders 875
Rectum, Carcinoma of, Operations.... 557
Rectum, Malformations of.... 606
Rectum, Musical.... 656
Reflex Pain 1050
Relaxation, A Thought on.... 694
Respiration, Forced.... 806
Retreating, On Graceful.... 895
Rheumatoid Arthritis 654
Road Improvement.... 630
Robb, Hunter, M. D.... 617
Rubella Diagnosed by Swollen Glands... 720
Salicylic Intoxication.... 589
Salol in Diarrhœa 965
Salpingitis, Chronic, Dr. Munde on 877
Sanger, Frank Dyer, M. D.... 837
Sanitarium, Thomas Wilson 739
Sanitarium, Lincoln Park, Chicago.... 868
Sanitary Crusade.... 1084
Savannah, Sanitary Needs 635
School Examinations Abolished 782
Scott, J. McP., M. D.... 869
Sea-Sickness Treatment.... 1071
Shimwell, Benjamin T., M. D.... 602
Silver Nitrate in Urethral Diseases.... 945
Skatalogical Medicine.... 873
Sleeplessness.... 1007
Snake-Bite in Australia 1096
Snake-Bite, Strychnia in.... 696
Snakes, Venomous, of United States.... 760

SOCIETY REPORTS.

Baltimore Medical Association.... 626
Clinical Society of Maryland. 584, 647, 846, 1018
Medical and Surgical Society, Baltimore. 606, 734
American Health Resort Association.... 867
German Surgical Association.... 820
Solis-Cohen, J., M. D. 815
Spermatic Cord, Torsion of 588
PAGE.
Spleen, Spontaneous Rupture of.... 1135
Sprains, Hot Water for.... 615
Stammering.... 744
Sterility Not Fostered by Education 963
Stomach, Hydrochloric Acid in Vomiting 676
Stomach-Washing, Dangers of.... 700
Strontium Salts, Therapy of.... 721
Strophanthus in Goitre.... 1033
Submersion 1049
Sugar, Phenyl-Hydrazin Test.... 1093
Sun-Stroke, Nature of.... 889
Teeth, Sensitive.... 1091
Tendon Plantaris, Rupture of 1018
Tendon Reflexes, Value of.. 959
Tetanus, Traumatic, Recovery from.... 903
Therapeutic Notes Arsenic in Eczema, etc. 744
Therapeutic Laboratory.... 849
Thomas, George, M. D.... 727
Thomas, Wm. Dulany, M. D.... 1064
Thorax, Surgery of 981
Throat Disease, Cases of Unsuspected Origin 925
Tongue, Cancers of 746
Tongue, Ulcers of 921
Tonsillotomy, Hæmorrhage, Ligature of Carotid 699
Tonsillotomy, Hæmorrhage After.... 1010
Tonsils, Functions of.... 963
Tonsils, Cysts of 680
Tonsils, Hypertrophied, Glycerin in 651
Trichinous Muscle, How to Mount.... 868
Tropacocaine.... 1112
Tubercular Sputum, Prophylaxis 837
Tuberculous Meat.... 979
Turpentine and Accident from.....632, 1099
Ulcer of Leg, Obstinate 809, 859
"Unprepared!".... 1022
Urethral Diseases, Nitrate of Silver in .. 945
Urethral Stricture, Radical Cure of 944
Urine-Casts, How to Collect Quickly.... 592
Uterine Catarrh of Girls.... 657
Uterine Versions 909
Uterus, Cancer of, Palliative Treatment. 676
Uterus, Rupture of, from Divulsion.... 658
Vacation Lodge 761
Vacation Notes.... 1000
Vacation Problem.... 912
Vagina, Absence of.... 608
Vaginal Examinations of Single Women. 744
Vaginal Injections Injurious.... 897
Vaginitis, Vesicular. 898
Varicella and Herpes 1092
Variola, Difficulty in Diagnosis 1031
Vaseline on Sounds Injurious.... 836
Vertigo, Varieties of 1115
Voice, Effect of Diet on.... 1042
Vulvo-Vaginitis in Children.... 705
Warts and Porpoises.... 874
Water-Drinking, Fatal.... 851
Watson, Wm. T., M. D.... 997
White, Alnard, M. D.....949, 1043
Whooping-Cough, Spray for.... 874
Williams, J. Whitridge, M. D.... 705
Williams, P. C., M. D.... 906
Wit, Southern.... 1052
Women, Medical Education in Glasgow.. 1021
Wounds, Bacteria in 611
Writer's Cramp Simulated by Epilepsy.. 792
Wry-Neck, Operation for.... 897

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CONTENTS

ORIGINAL ARTICLES.

Two Cases of Transverse Presentation Due to Uterus Bicornis. By Wm. S. Gardner, M. D., of Baltimore. 573

Influenza, from a Sanitary Point of View. By T. H. Buckler, Sr., M. D., of Baltimore. . 575

SOCIETY REPORTS.

Clinical Society of Maryland. Stated Meeting held March 18, 1892. Leukæmia. . . 584

EDITORIAL.

Dr. Buckler's Article. 586

Reform Needed at the City Hall. . . . 586

MEDICAL PROGRESS.

Forming the Character of the Unborn Infant.—Torsion of the Spermatic Cord.—Salicylic Intoxication.—Pyorrhœa Alveolaris, Mistaken for Facial Neuralgia.—Buffalo and its Health Department.—To Collect Urine-Casts Rapidly.—A Blue Baby.—The True Physician. . . 587

MEDICAL ITEMS. 593

Original Articles.

TWO CASES OF TRANSVERSE PRESENTATION DUE TO UTERUS BICORNIS.*

BY WILLIAM S. GARDNER, M. D.,

Lecturer on Obstetrics, College of Physicians and Surgeons; Attending Obstetrician Maternite Hospital, Baltimore.

CASE I.—White, multipara. In a previous confinement the child was born without difficulty, but the attending physician had much trouble in delivering the placenta; in fact, he failed entirely to find it. He then called in a consultant, who instead of going up into the uterus as he ordinarily would without reference to the cord, simply took the cord and followed it up to its point of insertion. The attending physician, previously, in attempting to remove this placenta, had passed his hand up into the uterus, but instead of getting into the portion of the uterus where the placenta was attached, passed his hand into the other horn of the uterus. I saw her in consultation during her second confinement. When I came to the case, the bag of waters had ruptured some hours previously, and entirely drained away. The child was presenting by one of the shoulders, and jammed down firmly in the pelvis. The uterus was contracted closely and firmly over the whole body of the child, and in a tetanic condition. Chloroform was administered, and after a great deal of difficulty the feet of the child were brought down, and it was delivered by podalic version. It was not weighed, but was unusually large, and probably weighed about nine pounds. The placenta was delivered without difficulty by the Crede method.

*Read at the meeting of the Gynæcological and Obstetrical Society of Baltimore, April 12th, 1892.

On digital examination, after the labor was completed, the hand could be passed through the vagina into either horn, holding the uterus up against the abdominal wall, where it could be distinctly shown to have two horns, separated from each other by a decided interval and the septum extending down into the cavity of the uterus below the point of junction on the outside.

The transverse presentation of the child in this case was evidently due to the fact that the uterus was divided into two portions and the greater diameter of the uterus was transversely, giving the child more room in that direction.

If the case had been diagnosed earlier, it is highly probable that a podalic version could have been done, and the child delivered alive.

CASE II.—No. 1815; white; age 24; primipara. Last menstruation, December 20th, 1890.

On examination before labor, found that the distance between the spines of the ilium was eleven inches, between the crests of the ilium, twelve inches. The external antero-posterior diameter 8½ inches. The figure of the patient was rather stout, the abdomen very wide and large, with thick abdominal wall.

The head could not be found in the superior strait in the usual position.

On either side of the abdomen were two apparently distinct tumors with a distinct crevice between them; but without an anæsthetic, and on account of the thickness and tenseness of the abdominal wall, it was extremely difficult to decide whether the shape of the abdomen and the size was due to a transverse presentation of a large child, or whether there was twin pregnancy. The appearance pointed rather to the latter, although it was not definitely decided which it could be, and an examination under chloroform was settled upon for some time in the near future.

Her labor began early in the morning of Sept. 20th, 1891; but having on hand another case of labor the same morning, I did not see her until about noon; at that time her pains were regular, cervix soft, dilating, and dilated to about half its extent.

No portion of the child was felt presenting through the cervix. Chloroform was given, and by external examination it was easily made out that the child was lying in a transverse position, the head well over into the right side, and the breech well over into the left. An attempt was now made to do cephalic version by external manipulation, but, after repeated trials, completely failed. I then passed my hand into the uterus, secured the head of the child, and brought it down to the superior strait; but in doing this the waters ruptured, and the cord prolapsed.

Knowing that the life of the child would be almost certainly lost if left in its present condition, I passed my hand farther into the uterus and took hold of the feet and did a podalic version. At this time I discovered for the first time the reason for my failure to do a cephalic version by external manipulation.

I found the obstruction to cephalic version to be a partition in the median line of the uterus, extending down to about the middle of the uterine cavity, so that when an attempt was made to push up the breech, or to push down the head, the breech would catch against this partition and could not be moved from its position. Both feet were secured, and the body of the child delivered without difficulty, but the head was retained by a rigid perineum. All efforts to deliver by manual manipulation were unavailing. Forceps were then applied, and the child finally delivered, living. As a result of the rapid delivery of the head by the forceps, there was a rupture of the perineum to the second degree.

The child weighed 8 pounds, 2 ounces, and was 20½ inches long. The

occipito-frontal diameter of the head was 4¾ in., the occipito-mental diameter 5⅝ in., the sub-occipito bregmatic, 4½ in., the biparietal, 3⅝ in., the circumference of the head around the occipito-frontal circumference was 14¼ in., the sub-occipito bregmatic, 13 in., the shoulders, 14½ in., the hips, 10¾ in.

As will be observed at a glance, the weight and measurements of this child are all considerably above the average. The placenta was delivered by the Crede method; it weighed 1 pound, 14 ounces; and its greatest breadth was 8 in., and its measurement at right angles to that was 6½ in. The cord was 25 in. long, and was without knots or varicosities. The rupture of the perineum was brought together by three stitches.

There was nothing unusual during the puerperal period. The pulse and temperature, the greater portion of that time, remained nearly normal.

After the uterus was emptied, by placing the forefinger in one horn of the uterus and the second finger in the other horn the uterus could be lifted up against the abdominal wall and the two horns could be not only distinctly felt, but could be distinctly seen. This bifurcation could be easily felt until involution had progressed so far that the uterus could be no longer felt above the pubis.

INFLUENZA, FROM A SANITARY POINT OF VIEW.

BY T. H. BUCKLER, SR., M. D., OF EVERGREEN, BALTIMORE.

WHAT TO DO ABOUT IT IS THE MOST SERIOUS QUESTION THE WORLD AT LARGE HAS EVER HAD TO DEAL WITH.
SEWERS AND SINKS THE SOURCES OF MOST OF THE NUMEROUS ZYMOTIC DISEASES, INCLUDING INFLUENZA; AND THE METHODS OF STAMPING THEM OUT FOREVER.

An individual, when asked what was the disease from which he suffered, said: "My doctor tells me that I have got the malaria," thus substituting the name of the cause of the disease, in place of the terms used to signify the effects of bad air, as, for example, quotidian, tertian, or quartan intermittent fever, benign or pernicious, etc. In the same way, if asked what influenza is, it might be defined not a disease, but a *relentless disease-producing atmosphere;* since under the synonyms influenza, *la grippe*, and *dengue* are included a number of well-recognized diseases, viz.: pneumonia, bronchial catarrh, bronchitis, rheumatism, rheumatic bronchitis, with or without endo- and pericarditis, corbature, neuritis, nervous prostration, leading on to exhaustion or death, and anæmia, etc.; in which cases the patient is often said to die of heart failure.

Not very long ago the excuses of the ignorant for death were "complications," but now it is "heart failure," and unless there is an entirely new departure in sanitary matters—a departure from old and an adherence to new doctrines, there is likely to be universal failure of half the vital organs in the people of the world.

During thirty years in Baltimore, not an autumn or early winter passed without a few or many cases of endemic influenza, and during a like period in Paris, more or less endemic cases of this disease occurred, but it was only in 1888-89 that there was a very marked increase of them over previous years. When, in a crowded assembly, every fourth or fifth person is heard to cough, snort, or sneeze, it may be known that influenza is in the air. In 1890, the general cause, whatever that may be, took its start in Eastern Russia. Having been epidemic in St. Petersburg, it went to Berlin and Brussels, and from thence to Paris, where it was at once recognized as an epidemic, differing from the endemic only in its universality, as it was not there many days before half the great postoffice staff were down with it, and most of the large industrial establishments had to

reduce their operations for lack of hands to carry them on. The epidemic was next heard of as being very bad at Havre and Bordeaux. Then it broke out on an emigrant vessel in mid ocean, and the next news was that la grippe had reached New York, from whence it went North, South and West, to San Francisco. Influenza has been most fatal to old people and young children who are incapable of helping themselves, and it behooves the active and intelligent to do all they can for them. It is appalling to think of the hecatombs of young creatures and the holocausts of old and middle aged people that have died in many countries during the influenza epidemic of the past two years. If during this period a universal war had been going on all over the world, the loss of life could hardly have been as great as the mortality which has taken place during the past two years from influenza alone. It is difficult to realize the extent of its ravages, since, as in wars, only the noted officers are gazetted; but what of the rank and file—the dumb millions, who have died in hospitals and in the humble cots of peasants, to say nothing of those, no matter by whom remembered or by whom forgot, who have been buried in Potter's fields, but to whom life was sweet, and basking in the sunshine was happiness. Doctor Smee, adviser of the London Life Insurance Companies, says the losses have been three and one-half times greater than in the great cholera epidemic of 1847; he is apprehensive that the influenza-poison may become so malignant as to be a terror to the world. Doctor Sisley, in a pamphlet read before the Medical Officers of Health, of London, a few days ago, says this disease is contagious—meaning no doubt, infectious—without question. The Angel of Death has been busy in Baltimore for some years, and large harvests of young children and old people have been gathered into several cemeteries, the lots in which are at a premium, still rising, and if the heavy mortality still continues, will have to be enlarged to accommodate the ever-increasing number of new-made graves.

A large number of children die from bacteria, which may, during the heated term, be scraped from the mouth-piece and neck of a neglected sucking bottle and also from the nipple of a slovenly nurse, who, in hot weather, should always wash the nipple before holding the child to nurse from it. Bacteria seem only to occur where the surrounding atmosphere is impure. Out of all the foundlings carried to the old Baltimore City and County Almshouse, during a period of eight years, only one (Billy Button), nursed from the breasts of a compassionate, cleanly woman, who took a fancy to him, survived. The last I saw of Button, then a boy seven years old, was at the Almshouse School for children. It would be interesting to know whatever became of him. Many children suffer and die during the heated term from the direct effects of high temperature, but this is easily avoided by allowing them to play to their great delight, during the large and small hours of the day, in a tub of water which has stood in the air the previous night.

It is needless to inquire how far the heavy death-rate is due to microbes, or to tainted air or water acting catalytically on the blood of the numerous victims; since both malaria and microbic germs originate from like sources. The object is to find out the origin of these perils to life, and by prompt action obliterate them forever. By improving sanitary measures, plague, Hecker's black death, the sweating disease, and Asiatic cholera, have been stamped out, and kept evermore from registering their victims, which formerly numbered many millions. But a step further must be taken, and the condition of sewers and sinks looked into, as prime causes of the epidemic influenza, from which the world now suffers. If "self-cleansing sewers," like those constructed by John Phillips, in the low-lying districts on both sides of the Thames, could be adopted in all towns,

sewers might still be permitted as safe conduits for carrying off house drainage or sewage from water-closets, kitchens, washhouses, etc.; but this is impossible, since there was one John Phillips and is not likely to be another—besides which, the cost of his sewers was very great.

Starting in a train from Leamington for Birmingham in 1870, a man seated by my side informed me that every house in Birmingham had connected with it a sink; that he had been trying for twelve years to get rid of all these disgusting cesspools; and he asked me if there was any way to abolish them, which he thought might be done if some efficient method could be devised for carrying house drainage to some remote point, beyond the city limits. He further said, "I believe these conservatories to be the source of all the scarlatina and erysipelas, besides many other diseases prevalent here. For years I spent all of my time and income in collecting a gallery of paintings, but I care no longer for art, and shall spend all my remaining days in fighting sewers and sinks, believing that in this way I can be more useful to my fellow-creatures than in any other work I could possibly undertake." In reply, he was informed that in my opinion he would only be throwing his time away; that before leaving Baltimore I had written six letters to the *Sun*, explaining the evils, and injurious effects on health, of cesspools, and causing many people to believe that nine-tenths of the diseases which physicians in general practice had under care were due solely and entirely to the disease-engendering effects of sewers and sinks, especially the latter, with which the city abounded; but that no steps had been taken looking to their removal. As well might you attempt to storm Gibraltar with pop-guns. Sewers and sinks are promoted, fostered, and approved by municipalities everywhere. When either of these institutions enter a town, they come to stay. The Cloaca Maxima was in Rome some 2,000 years ago, is there now, and unless people can be educated up to your advanced standard in sanitary knowledge, the father of sewers is likely to remain in Rome till doomsday. Depend on it, sewers and sinks will continue to do their lethal work, and are not to be carried by assault, stratagem or siege.

He has passed away and his gallery of paintings has gone into other hands for an enormous sum; but the sinks of Birmingham are there yet in their indestructible glory. Kingdoms will pass away, while the sewers and sinks within their borders will remain undisturbed. Just before reaching Birmingham, my disgruntled cesspool companion presented me with two cards, remarking that I might like to see his paintings and his steel-pen factory, when I discovered that I had been talking to Gillott, the famous pen-maker, and a sterling millionaire three times over. Asked if he was aware that much use of steel pens often produced *paralysis scriptorius*, he replied "O, I don't care about that, the causes of disease I am at war with are those that produce death. I never see a funeral, I don't exclaim, 'there goes another victim of the sewers and sinks.' " He further said, "to get rid of the cherished nuisances of my neighbors and of the corporation, I shall spend the rest of my days in the country, where I shall have all sanitary requirements under my own control, and I'm far enough from Birmingham to escape the ill effects of its bouquet of sinks; and if the sinks are abolished I shall move back to the city." I did not then know anything about the "iron pipe and tank system of drainage," about which I shall speak presently, or Mr. Gillott, much to his gratification, would have been told of it.

The present epidemic, as well as the influenza of last year, began during the early autumn of 1890, in Eastern Russia. Like Asiatic cholera, its general cause came from the East and was only operative where it encountered local impurities,

such as stagnant ponds, pig pens, sinks and sewers, decomposing garbage, etc., the exhalations from which serve to ignite and bring it into disease-producing action. In other words, it was only at the cross roads where the local and general causes met, that either of these epidemical diseases did, or ever will, appear. There was this difference in their modes of approach: The death-march of Asiatic cholera was always during summer; while the campaigns of epidemic influenza, commencing in the autumn, were continued through the winter and the early months of spring Asiatic cholera came by the lines of travel, the intermediate and remote countries escaping its ravages; while influenza, on the contrary, like a great sanitary inspector, was world-wide, pervading the country in all directions and searching out every nook, corner and cranny in both hemispheres where impurities of any sort or kind existed, and pervading these vast regions everywhere, it measured and gauged exactly the sanitary condition of every town, city, village, homestead and country place, no matter how isolated, in the Northern Hemisphere. Places where no local impurities existed passed muster and the general cause of influenza went by, leaving them entirely unscathed, while places in the neighborhood, whose sanitary condition was more or less out of order, were visited according to their deserts; showing conclusively that the first action of the epidemic causes newly imported is not on the individuals, but on the impurities by which they are surrounded, and of course no towns escape, because there are none that do not have either sewers or sinks, or both. Residents of rural districts are notoriously regardless of sanitary precautions; almost every country dwelling has a sink near it, and often a pig pen or heap of decaying garbage, all of which are invitations to the general imported stranger, and they could not, of course, hope to escape the epidemic. But there were some places in perfect sanitary condition, and they, as far as heard from, escaped—the home, for example, of a member of the French Chamber of Deputies, who for years has not only had the pens in which pigs were kept scoured every morning, but causes the hogs to take a bath and their faces to be washed daily with as much care as if they were infants—and there are, within my knowledge, several other isolated country places that have escaped the influenza entirely; to them it could only be carried by some victim suffering from influenza. The brilliant crimson sunsets seen all over the world, about four years ago, came also from the East, and since scientists say they were due to particles resulting from the Java earthquake, suspended in the atmosphere, it looks as if the air surrounding the earth's surface, blown by the winds, silted during the daily revolution of the globe, and held the particles suspended at all points. If this be true, why may not morbific influences be carried Westward in the same way? It is to be hoped that the causes so destructive to the culture of grain, in Eastern Russia, may not, in like manner, be brought to the Western Hemisphere.

I saw in a paper, about Christmas last, that a town of two thousand inhabitants in Western Virginia had six hundred down with influenza. Perhaps, like all the towns in France, it was afflicted with cesspools. In fact, all the peasant populations in Europe have these conservatories of filth, often supplemented with a dung-hill in close proximity to the dwelling, which would not be so bad if they did not make it a repository for garbage. Amongst the rural peasant populations of Europe a manure heap is often given as a marriage dower.

A son-in-law of Koch, Dr. Richard Pfeiffer, of Berlin, announces that he has discovered the influenza bacillus, which may or may not be son-in-law or kith and kin of some kind to the tuberculous bacillus of phthisis discovered, or the questionable microbe of Asiatic cholera, not yet unveiled by his father-in-law, Dr.

Koch. All such statements should be received with more than a grain of salt, since amongst the very numerous varieties of microbes, benign and lethal, the difficulty is to detect, identify, and convict the guilty and murderous individual or family. It is like searching for Jack the Ripper amongst a crowd of convicts. Microbic inquirers are often beset by problems most abstruse and recondite. The unexplored path is dubious and surrounded on all sides by fallacies. If Dr. Pfeiffer means to say he has discovered a microbe indicative of the morbific atmosphere giving rise to epidemic influenza, one element of which is domestic and the other imported, his announcement is absurd, and should consign him and his bacillus to the boundless domain of the irresponsible inane. No doubt Dr. Pfeiffer has found in the dead bodies of influenza patients a bacillus, and will cultivate it; but to what end, or for what useful object, will he do so?

Had he said he had found and identified a microbe surely indicating one of the diseases caused by the influenza atmosphere, pneumonia for example, there might at least be a shadow of probability in it; but in this case he might have announced a rival to Germain Sée's bacillus, since he wrote, more than a year ago, that he had found in the bronchial tubes of patients who had died of pneumonia, a microbe which he named "spirillus."†

The single great discovery Koch made was that the bacilli of phthisis could be rendered non-translucent by the coloring matter of gentian and by the aniline dyes, whereby they are made visible under a lens of moderate magnifying power, through which he saw the stained bacilli or rods. The first announcement of his discovery was in a letter to Professor Tyndall, occupying a column in the London *Times*. His next discovery was the supposed and very questionable cholera bacillus. His next supposed discovery was that the lung-destroying bacilli could be starved out and tuberculous phthisis "cured," by injecting into the muscular structures of the back a peculiar and subtle poison, on the principle, it may be supposed, that one fire puts out another's burning. Had he not been entirely ignorant of the etiology of phthisis, and of nature's methods of repairing lungs disorganized by tuberculous deposit, he never would have supposed it possible to remedy tuberculous lesions by hypodermic injections of any kind, and except for a want of like knowledge the shoals of doctors from all parts of the world, who went to Berlin "to study the Koch method," would have remained quietly at home, and thus have avoided proclaiming to the world their lamentable and most deplorable ignorance. No single pathological discovery has yet pointed out at once the methods and means by which it may be relieved. It would appear that Koch and his disciples have yet to learn that the greatest physician in the world is he who most successfully studies and finds out nature's methods of restoration and cure, and who is, and proudly declares himself to be, the humblest servant and assistant of Dame Nature. And then Koch asked for and has obtained a hospital for the treatment and "cure" of consumption. In keeping the record of his cases, if he puts "cured" on one page, he ought surely to put, antithetically, on the opposite page, "killed." But it would be better to use the headings "recovered" and "died." Dr. Koch may charge his hypodermic with any sort of therapeutic ammunition he pleases, and shoot it into as many hospital patients as are to be found; but if he only will repeat the hypodermic discharges and keep them under care long enough, he will find they will all come under the black letter list—died: hospital atmosphere being quite sufficient to kill them, without the aid of lethal hypodermics.

Every medical tyro knows that those suffering from tuberculous phthisis,

†Not the spirilla of Obermeier.

matter how early in its course, who succumb and go tamely to bed in a ward to be treated for consumption, all die; while on the contrary the vicious, profligate, and vagrant who, impatient of care and restraint, go about in the open air, regardless often of weather, improve, and, escaping intercurrent pneumonia, in many instances recover entirely. So that Koch's hospital for consumptives may be regarded as little else than a mausoleum for the living. Since Dr. Koch and his staff claim to be studying preventive medicine, might they not do well to turn their attention to the sewers and sinks of Berlin, and see whether the tainted air and microbic disease-producing organisms generating in them may not be abated or abolished altogether? In place of laboriously hunting for a lethal bacillus of questionable value when discovered, how much more sensible it would be to destroy the sinks in which multitudes of microbes are born, bred, and trained to be, like the splendid German Army, murderers by profession.

One wide-spread fallacy—homœopathy—has already come out of Germany; but since its leading doctrines "like cures like" and "infinitesimal doses," which gave nature a chance to make cures in her own way, have been abandoned, this system of medicine seems to be dying out, and its place to be taken by the doctrines of Don Cæsar Matæi, of Bologna, Italy. And, in turn, it looks as if the germ theories of Dr. Koch are destined to end in a like fad, consisting in the use of supposed remedies of germicidal powers.

If influenza and all other zymotic diseases are ever to be stamped out, it must be accomplished by abolishing the sources from which the poisons giving rise to them are derived. In other words, it must be done by prevention, and not by discovering, in the cadavers of the victims, lethal bacilli, and then searching for germicidal remedies to destroy them: since efforts to do so must prove no less abortive than the attempts made to destroy the bacilli of tuberculous phthisis.

No; the only true way is to bring health, strength and vitality up to such a point of excellence as will override morbid tendencies, and not only resist the destruction of tissues caused by bacilli, but render these latter sterile and unproductive; so that the remaining ones die out, and vitality, no longer oppressed by the lethal effects of these parasites, takes a new vigorous start, and the victims recover. In other words, they are cured; "cured" being a most imperious word, philologically unmeaning, which has served, more than any other, to retard the progress of scientific medicine.

We have not far to seek for tainted air infusoria and death-dealing microbes, in Baltimore, since teeming multitudes of the minute creatures are engendered in warm weather by the ferment going on in some 200,000 seething cesspools,—say some 200,000 sinks. What an endowment! What a multiple institution of filthy conservatories! What a municipal bequest to future generations! If the disease-engendering powers of sewers and sinks have not been learned before from the oracle, Common Sense, then conviction of their baneful influence may be reached by the method of exclusion, which shows that the tainted air and microbes afflicting the inhabitants of towns and cities must come out of sewers and sinks, since, excluding them, there is no other possible source or sources from which they could in any way be derived. These 200,000 sinks brought together would form a lake covering several acres. It is worth noting how frequently influenza and diphtheria occur together in the same localities and at the same time, both being the outcome of sewers and sinks.

The question is, How can the contents of all these conservatories of filth, including kitchen and wash-water, be gotten rid of, and carried where it will do no

harm? Without hesitation, the answer is: By constructing the pipe and tank system of drainage, first established at Memphis, Tenn., after the yellow fever scourge there, and since set forth and recommended as peculiarly applicable to Baltimore, in an able and exhaustive pamphlet by Mr. Charles Latrobe. The late able engineer, Charles Manning, endorsing Mr. Latrobe's views, highly approved of it, for Baltimore, both on the ground of efficiency and cheapness. In reading this clever pamphlet throughout, it struck me as having on it the stamp of his uncle, the late J. H. B. Latrobe, and it is impossible not to suspect that he had a hand in its production. Sixty years ago it was generally said that J. H. B. Latrobe should have been the engineer and his brother Benjamin the lawyer. Whatever the value of this opinion may have been, one thing is certain, that both brothers were distinguished in their respective professions. It must be considered most fortunate that no system of underground elongated, hidden cesspools, miscalled sewers, was ever adopted in Baltimore, since the pipe and tank system will be about one-tenth the cost of well-constructed sewers, and is altogether better suited for the end sought to be obtained. As to the rainfall on streets, houses and vacant lots, it will take care of itself and run off by the natural inclines for which Baltimore is so remarkable, having no less than five streams flowing through it to the harbor.

Very careful calculations should be made as to the sizes required for the upper, middle and lower ranges of pipes, before they reach the large effluent pipe or pipes leading to Back River or the upper Chesapeake Bay. The pipe and tank system was evidently arranged at Memphis for whole drainage, or to perform the office of sewers, carrying off not only the rainfall, but house drainage also. But for Baltimore, the tanks may be dispensed with, the pipes alone being quite sufficient for the single and specific purpose of carrying off house drainage only. The pipes would require stopper-openings in place of tanks, at various points, for the purpose of flushing them at any time required. I earnestly advise therefore that the city get about this work without delay, since no time would be more opportune than the present for its accomplishment. Money can be had on the credit of the city at 3½ per cent., and iron, the chief cost, is lower now than it has been for years or is likely to be for years to come.

This pipe system of drainage is particularly applicable to Baltimore, where most houses run back to alleys, along which the pipes could be buried and house drains attached to them, without the necessity of tearing up the front pavements, as is done when house drains are connected with street sewers; and there will always be a superabundance of water to flush the pipes when required. Wash water, thrown now into the gutters, rendering them as filthy as the Falstaff buck basket, should also be made to flow through the iron pipes. As preliminary to the undertaking, it will be necessary to have made a topographic map of the city by triangulation, similar to the map made for me by Mr. Faul, of all the region about the basin, Whetstone Point, and the Spring Gardens, noting the height of every elevation, depression and incline above tide, for which I paid him $2,500, which map must have been left amongst the papers of Mr. Benjamin Latrobe, since it was he who supervised Faul's survey. Let this work be done to encourage all towns, cities and villages in the United States and Europe which have sinks to follow the example.

Sewers and sinks are peculiarly the outcome of Christian civilization, since in India and China and most other pagan lands there are different modes of disposing of human ordures. If all christendom had their noses begrimed daily in these abominations, the infliction would be mild compared with breathing into

their lungs, day and night, the exhalations from these seething pools of nastinesses, mixed with atmospheric air, thereby corrupting the blood of unsuspecting millions who take in at one breath the poison of scarlatina; at another of diphtheria; at another of erysipelas; at yet one other, the bundle of diseases billetted "influenza;" and at still another, the budget of maladies labeled malarial, etc. To say in these days of wondrous engineering, that there is no other way of providing for the offices of sewers and sinks and giving relief to the sickening and dying denizens of thousands of communities, is surely a satire on the intelligence and boasted progress of the nineteenth century. In primitive times excuses might have been found for the construction of sinks; but surely in these days of enlightenment, the promoters and builders of sinks should find no refuge but that of the grossest ignorance. These sinks are sometimes man-traps. In 1885, at Biarritz, France, a basque, reported to be the handsomest man in Europe, was seen playing with his dogs on a field near the town. On his way home he was informed that a man overcome by gas had just fallen into a cesspool. He rushed down a ladder, seized the man and dragged him to within one round of the top, when he too, overcome by gas, fell back with his charge into the seething pool of nastiness ten feet deep.

But the question for Baltimore is also the world's question, since there are few dwelling places in christendom that are not cursed with either sewers or sinks.

The sewerage of Paris was constructed originally for the sole purpose of carrying off the rainfall alone, and for this purpose the sewers in all the streets and avennes in Paris were preserved intact, until the close of the Franco-German war; but under the republic proprietors desiring cellar room have been allowed to remove the cisterns from underneath their houses, and to carry the drainage of the latter into the adjacent sewers. Twenty years ago, every house in Paris had underneath it a cistern to receive all the house drainage, which was pumped out every three or four months, and carried away in water-tight carts. The exceptions, hardly worth mentioning, are in localities where cellar-room is very valuable. In these places tin cylinders, 18 inches in diameter and 8 or 10 feet long, with strainers at their lower ends, are screwed on to the waste-pipe. This *fosse*, or cylinder, retains all solid matters, while the liquids run through the strainers and are voided into the sewers; when full, these cylinders are removed, and empty ones are screwed on in their places. This system could be adopted only in towns already provided with sewers.

An invitation to visit the sewers, amongst the other sights of Paris, no longer appears as of old in the daily papers. This lapse was caused by the acts of sanitary desecration which commenced after the Rothschild purchase of the Chatteau La Fite and Mouton vineyards, when it became the fashion for moneyed men to buy other vineyards; and having no suitable place wherein to store their wines, they dispensed with the cesspools and made "dug-onts" underneath their houses, where they knew they would be safe. To do this, the ground had to be cleared by carrying a house drain to the sewer. It may be said without fear of contradiction, that if many more house drains are carried to the sewers, Paris will be made the most unhealthy city in Europe, since its people will be under a cross-fire between cesspools on the one hand, and filthy sewers on the other. The municipality of Paris should restore the sewers to their pristine function of carrying off the rainfall alone, and then construct a special system of conduits to take away house sewage and thereby abolish suboical cesspools forever. If this is not done, cesspools and sewers will prove much more dangerous to Paris than the

anarchists, and much harder to get rid of; the former being institutions, while the latter are mere bipeds of unsettled minds.

If S. T. Coleridge, in place of writing Aids to Reflection, Confessions, and other theological essays, had with his strong reasoning powers, rare understanding, and translucent logic, devoted his latter days to sanitary matters, he might have saved the world from multitudinous sorrows, the value of life would have been much greater, and most zymotic diseases would have become known only to history. In denouncing by poetic philippic, the horrors of Cologne, he struck the right chord. Had he been made a member of the Board of Works, in place of ordering Sir J. Buzelgett to construct intercepting sewers on both sides of the Thames to prevent pollution of its waters, he would have directed that the pure rainfall be allowed to flow by sewers into the river, and that other conduits be constructed, to carry house drainage alone, to its present remote destination below London, or to the North Sea. Make use of a double system of drainage and zymotic diseases of all sorts, influenza included, will be forever stamped out and become like plague diseases of the past.

For if zymotic diseases, the outcome of putrid fermentation, do not originate in the sewers, from what other possible source can they come? The lines are here quoted to remind the reader that the scathing invective tirade was not aimed so much at sewers and sinks, but directed against the city gods, meaning the Lord Mayor and Aldermen, and members of the London County Council, who not only rule over them, but originate, promote, construct and perpetuate them, to the injury of the public health. The great sanitary pioneer says:

In Cologne, a town of monks and bones,
And pavements fanged with murderous stones,
And rags, and hags, and hideous wenches,
I counted two-and-seventy stenches,
All well defined and several stinks!

Ye gods that reign o'er sewers and sinks,
The River Rhine, it is well known,
Doth wash your City of Cologne;
But tell me, nymphs, what power divine,
Shall henceforth wash the River Rhine.

The diseases of christendom are mainly due to slow decay going on in sewers and sinks, and the words "rot" and "slaughter" would seem clearly to typify the present sanitary condition of the civilized world.

It is hoped the London County Council may be wiser than the Board of Works; but they may consider the proposal to let only rain-water run through the sewers liable to the objection that these conduits would be kept altogether too clean. This honorable body can surely bring no objection to the proposal to construct a separate set of conduits for house drainage, except that physicians would lose their occupation and druggists would be obliged for lack of business to close their doors. After the sad experience of the past two years, the gods who reign o'er London sewers ought to be willing to do almost anything and make any sacrifice to improve the health of the great metropolis.

In Paris, London, New York, and all other large towns, the foul air, often charged with infinitely minute microbes, is driven out of the sewers by the first cool autumn rains which run into them. From the outer air these infinitesimal creatures get into warm rooms, kitchens, and especially into the warm air passages of their victims, where they flourish and enjoy a most prolific existence. A notable example of a confined influenza atmosphere was furnished by what oc-

curred in the British House of Commons during the short autumn session of 1890, when so many members contracted influenza that it was often difficult to form a quorum for the dispatch of business. After the final adjournment, experts, employed to find out the cause of the pestilent atmosphere, decided that it was due to imperfect drainage and insufficient ventilation. Air was supplied by an opening in the roof, and strained by being made to pass through chemically prepared raw cotton. Every few days the cotton, charged with all sorts of impurities, is removed, and fresh cotton is put in its place.

It is to be hoped that London and Paris will, at an early day, adopt and establish the double system of drainage, and thus set examples to all the towns in England and France cursed with sinks and sewers. If the London sewers are used to carry off the rainfall only, they might also be utilized for the passage of telegraph and telephone wires, and for pneumatic tubes, as is done in Paris.

As long as sewers and sinks were believed by many to promote health, there was a reason for maintaining them, but when they are known to be prolific sources of disease, it is time they should be abolished or converted into harmless uses. In order that the lugubrious forebodings of Doctor Smee, of London, may never come to pass, health officers throughout the world should abolish sewers and sinks, and remove from their respective towns all other impurities that might extend invitations to the general epidemic influence.

What euphemistic phrases may be used to countervail the advice herein given, it is impossible to conjecture: but if any Doctor Fillgraves differs in opinion and deems the advice ill-considered or wrong, he will kindly point out wherein the error lies.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD MAR. 18, 1892.

The 264th regular meeting of the Society was called to order by the President, Dr. Robert W. Johnson.

Dr. W. S. Thayer reported a case of LEUKÆMIA and exhibited the patient. The patient, a colored man of about 30 years of age, first reported to the Johns Hopkins Hospital, September 15, 1890. Complained of shortness of breath, swelling of feet and great swelling of abdomen. The spleen was found to be enormously enlarged, filling up the whole of the left side of the abdomen and reaching beyond the median line. Examination of the blood showed one white to four red corpuscles. There was no history of malaria. He was placed upon Fowler's solution, three minims *ter in die*, increased by one minim every other day, until physiological effects appeared. In about four weeks the proportion of white to red corpuscles was one to seventeen. He then returned home to Virginia and ceased to take medicine. He came back again January 29, 1891, his blood at that time showing a proportion of one white to three red corpuscles. He was put upon arsenic and within 19 days the leucocytosis had entirely disappeared. May 27 he went away feeling very much better. His white corpuscles were normal and his red corpuscles numbered 4,000,000 in the cubic millimetre. His spleen, which had touched on the right Poupart's ligament, was reduced in size, extending only a hand's breadth below the the costal margin. He took arsenic in increasing doses until the dose reached 12 or 13 minims *ter in die*. When physiological symptoms appeared, the dose was reduced and then started up again.

He took 12 minims regularly for a matter of two months without any symptoms. Nothing was heard of the patient for eight and one-half months. On February 9th of this year he returned. He said he had felt perfectly well until last Christmas. An examination revealed that his spleen was larger than ever before, legs œdematous and a proportion of one white to every nine red corpuscles. After a week's treatment in the dispensary he was admitted to the hospital, where he has been for four weeks. During this time the red corpuscles have increased from 2,700,000 to 3,400,000 and the white have diminished so that the proportion instead of being one to nine is now one to thirty-five. He has gained ten pounds. His spleen is somewhat diminished in size, and his general condition has improved very much. His reaction to arsenic each time has been very striking. It is in this condition with enlarged spleen that treatment seems to do most good. Some cases are reported where there seems to have been a definite recovery.

Dr. J. E. Michael: Only a few years ago this case would have passed for a malarial one in the hands of the general practitioner, especially as the man comes from a malarial region. We owe a debt to Dr. Thayer for the thorough way in which he has presented the case to the Society.

Dr. Joseph T. Smith read a paper on THE BLOOD IN DISEASE. (See page 507.)

Dr. J. F. Martenet, referring to a case mentioned by him at a previous meeting, of a woman suffering from acute mania associated with ovarian excitement, stated that the patient had been operated upon by Dr. Rohe at the State Insane Asylum. A week after the operation, Dr. Rohe wrote that after she had rallied from the operation her mind was perfectly clear and continued to be ever since. Previous to the operation she was one of the worst patients in the asylum. The nature of the operation, Dr. Martenet thought, was the removal of the ovaries.

On motion of Dr. Michael, the following resolution was adopted: That the Clinical Society enter its protest against the proposed reduction in the appropriation for the Library of the Surgeon-General's Office at Washington, and that the President be directed to send this protest to the Congressmen representing the State.

1519 N. Broadway. W. T. WATSON, M. D., Secretary.

LETTUCE.

Although preparations of lettuce have from very early times had a reputation in medicine for their soporific properties, the narcotic constituent of the plant has never been ascertained with any certainty. Various neutral, fatty, and waxy bodies separated from the milky sap of different species of Lactuca have been from time to time described as compounds of medicinal value, but on the other hand it has been denied that the dried milk-sap, lactucarium, in spite of its narcotic odor, possesses any sedative action, and in fact this preparation is no longer officinal in England or the United States. It is therefore interesting to learn in a communication from the Research Laboratory of the Pharmaceutical Society, read recently before the Clinical Society, that Mr. T. S. Dymond has established beyond doubt the presence of hyoscyamine, the principal alkaloid of belladonna and henbane, not only in the cabbage and Cos varieties of the common lettuce, L. sativa, but also in the wild lettuce, L. virosa. The amount in the young plants is certainly very minute, but in the officinal green extract, which, according to the directions of the "British Pharmacopœia," is to be prepared from the flowering herb of L. virosa, the mydriatic alkaloid occurs to the extent of 0.02 per cent.—*Science,* April 8.

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BALTIMORE, APRIL 30, 1892.

Editorial.

DR. BUCKLER'S ARTICLE.

We take pleasure in presenting in another column the views of Dr. Thomas Buckler on city sanitation. A physician who can write with such clearness and vigor at the age of 80 years may be considered to know something, at least, about the laws of health.

The author was already an experienced physician when the great cholera epidemic of the forties struck this city, and has ever since urged with vigor the claims of general sanitation upon our citizens. His experience of many years in the practice of medicine in Paris has given him an insight into the sanitary arrangements of that great and beautiful city. He is the only physician known to us who has repeatedly urged upon our city government, at great personal expense, by the publication of pamphlets and otherwise, the need of extensive and far-reaching sanitary undertakings for the improvement of our city. The records of these counsels are preserved in our medical library. Some have been adopted, some rejected or neglected by our rulers: but all will repay the perusal and reflect credit on the public spirit and the far-reaching thoughtfulness of the author.

Dr. Quinan, in his *Medical Annals of Baltimore*, says: "His book upon the epidemic of cholera as seen at the almshouse is one of the most eloquent sermons on sanitation extant."

REFORM NEEDED AT THE CITY HALL.

We learn from a reference in the *Baltimore American* that the Mayor, in his last message, recommended the reorganization of three of the city departments. One of these is the Street Cleaning Department, which spent last year $283,000. It ought not to take this much money to remove the dead cats and dogs from our alleys. There ought to be some surplus to spend in sweeping the streets, at least in business thoroughfares. It is estimated that a business firm could keep

the streets reasonably clean for one-third the amount expended in leaving them dirty by the strange medley of political workers which flourishes under the name of "Street Cleaning Department." In this interesting institution every subordinate is independent of his superior, being appointed and maintained by some local boss, before whom the superior himself trembles.

We hope the Mayor will sometime take a look at the working of our Health Department, which is run on the same principles as the other, and is about as efficient. We would recommend to his honor a consideration of the resolutions passed on this subject by the Clinical Society last November, asking for the appointment of physicians as sanitary inspectors.

As far as we can learn from physicians, the present methods of inspection are usually valueless and often a nuisance. How the collection of imperfect statistics at the City Hall repays the citizen for the support of the Inspectorial Staff is a mystery; unless it proves that the spread of infectious diseases is not checked by the methods now in use. We are too old now and "set in our ways" to be convinced that the filthy alleys and foul cesspools and damp houses with which our city abounds will not breed more ill-health and disease germs in a month than the inspectorial force will destroy in a century.

A force of *medical* inspectors might be of some use to the community; since they would at least be capable of helping the attending physician in getting the premises and dwelling rooms of the sick into a sanitary condition.

The *Baltimore American* deserves our thanks for speaking out boldly on this subject, which touches the life of every citizen.

Medical Progress.

FORMING THE CHARACTER OF THE UNBORN INFANT.

Dr. F. W. Moffitt, of Superior, Neb., writes thus to the *Med. Record:* It may seem rather late to again bring up the subject of maternal impressions. But there is a side to this question which I have not seen touched upon. If the reader of this ever indulges in novels to any great extent, he has probably read, or at least heard of, a novel, which only a few years ago attracted considerable criticism, both friendly and adverse.

The novel I refer to is "Mal Moulée." In all the criticisms I ever read the main subject matter, maternal impressions, seemed to meet with little comment. In describing the characters of the heroine and her schoolmate friend, there was ascribed to each certain governing characteristics, exalting and beautifying the life of the one and finally wrecking that of the other, and which seemed to be largely due to maternal impressions. The authoress, I think, sought to present her own and her mother's views upon the subject, thoroughly believing her own sweet rhyming to be the result largely of such pre-natal forces.

The authoress's mother upon one occasion imparted to the writer her opinion in the premises, supplementing them by the following illustrations. The words and sequence of pregnancies are, so near as I remember them, her own.

"Now, doctor, I do believe in maternal impressions, and for very good reasons, as I'll tell you. When I was first pregnant I wished my offspring to be a

musician. So during the whole period of that pregnancy I settled my whole mind on music, attending every musical entertainment I possibly could. I had my husband, who has a fine violin, and who is a good violinist, play for me by the hour. When the child was born it was a girl, which grew and prospered, and finally became, as you've undoubtedly heard, an elegant musician, a first-class one.

"During the period of my second conception I wished the offspring to be an editor, and I bent my whole mind to the attainment of such result. I read the papers almost continuously, paying especial attention to the leading editorials of such of the great periodicals and dailies of that time as I could lay hands on, even neglecting some of the smaller household duties in my efforts to attain the desired results. The child being a male, I expected my hopes to be realized. And although doomed to disappointment, everyone who reads his letters says he ought to have been an editor.

"When I was carrying my third child, I put my whole energies to bring forth a poet. I read poetry, doted on it, lived in it, and when, during waking, unable to read it, I thought of it, and when asleep dreamed of it. And, Byron being my favorite poet, I devoted to him more than a due proportion of my reading, and, doctor, my daughter is a poetess, and her poems partake so much of the noble grandeur of Byron that her critics have often asked her why she didn't copy some one else part of the time.

"When I became next pregnant my desires had been satisfied, I didn't care what he was: *and he is.*"

While not convinced, I had to acknowledge that she had the weight of evidence against me. For, as she had said, in regard to those facts with which I was not personally cognizant, I had heard her assertions corroborated by those who were old acquaintances. Was she right or wrong? I give it up. But of this much I feel assured, that any one, especially a prospective mother, can, by a careful perusal of "Mal Moulée," do herself no possible damage and may place herself in the way of vastly improving that portion of the world she is destined to repopulate.

TORSION OF THE SPERMATIC CORD.

At a recent meeting of the Royal Medical and Chirurgical Society (*Lancet*, February 27, 1892), Dr. Thomas Bryant communicated a paper on torsion of the spermatic cord, with strangulation of the testicle. The author recorded a case of this hitherto unrecognized affection, which occurred in a boy aged fifteen, with an imperfectly descended testicle, and which he saw in consultation with Dr. Fox, of Barnet, in September, 1889. The case in many points simulated one of strangulated hernia; indeed, it was at first so diagnosed. In an exploratory operation undertaken for its relief its true nature was at once revealed, when an imperfectly descended testicle, black from venous congestion, brought about by complete torsion of the cord, was exposed. Three half-twists made inwards completely untwisted the cord, and an attempt was made to save the testicle, as it was quite warm. The wound healed kindly after the operation, but the testicle wasted. A good recovery ensued. When the case first occurred it was thought to have been unique, but in the summer of 1891 a preparation was forwarded by Mr. G. Nash, of the South Devon Hospital, to the Royal College of Surgeons for examination, which was clearly of the same kind. This case is therefore fully quoted by the author, with the account of the preparation as given by Mr. Targett, the Pathological Curator to the College. In both of the cases brought forward the twisting of the cord took place in boys; in both the accident affected the

left side, and in both there was an incomplete descent of the affected testicle. In this author's case the torsion took place within the inguinal canal: in Mr. Nash's case it was reported to have occurred in the external ring. No explanation of the process by which the torsion of the cord was brought about is attempted, for the author states that neither accident, nor any of the changes which take place in the organ during its physiological descent, seem capable of helping towards a solution of the problem. That cases similar to the two now published have occurred before, the author has no doubt, and he is equally sure that such cases have been described amongst those of inflammation of an ectopic testicle. He believed that one such has been published by Mr. Jacobson (p. 471 in vol. iii of Mr. Holmes's last edition of his "System of Surgery"). He also maintained that if his case had not been operated upon, its true nature would never have been recognized; and if it had been allowed to run its natural course, it would probably have been described as one of gangrene or disorganization of the testicle from acute inflammation. He was disposed to think that many of the cases of atrophy of the testicle which has taken place after a supposed inflammation coming on without any clear cause are of this nature, the strangulation of the cord in such cases being less severe. As an appendix to the paper the author gave a case of the same kind, which was reported to him by Dr. W. Keen, of Philadelphia, United States, and which in every way supports the views put forward by the author.

The Secretary then read a communication from Mr. Bland Sutton describing a specimen of Axial Rotation of the Testis in an old pug dog, and the specimen was exhibited. In it the cord of the right testicle (which contained a large tumor) had rotated (as shown in the annexed figure) two and a half times. Cases similar to that of Dr. Bryant had been described by Nicoladoni and Cohen in Germany and abstracts are furnished by Bramann in vol. 40 of Langenbeck's *Archives*. (Some further discussion followed.)

SALICYLIC INTOXICATION.

In relating a case in which a state resembling delirium tremens was induced by salicylate of soda, Dr. F. W. Mann, of Detroit, says (*Med. Rec.*, February 13, 1892):

The physiological actions of salicylic acid have been so thoroughly worked out in the laboratory, and these have been so generally confirmed by clinical experience, that any extreme deviation from the recognized order of phenomena accompanying the administration of this drug is rare and unusual. The toxic dangers of salicylic acid are usually esteemed to be those due to its action as a cardiac or respiratory depressant, and these are always in the mind of the watchful physician. The toxic effect of the drug on the central nervous system is also a matter of common experience, and numerous observers have reported subacute delirium as a symptom occurring coincidently with its administration. Sometimes well-marked delusions have been noted, and refusal to take food for some cause or other has been a frequent incident of the delirium so produced. It is seldom, however, that anything like acute mania has been known to proceed from the use of this drug, and the case below recorded may, therefore, possess passing interest.

Salicylic-acid poisoning is said to be most effectively treated by diuretics. The excretion by the kidney of salicylic acid in the form of salicyluric acid and salicin is the natural safeguard in excessive administration. The occasional occurrence of such cases as the one now recorded lends emphasis to Germain Sée's injunction that salicylic acid should never be administered without a diuretic as an adjuvant.

PYORRHŒA ALVEOLARIS, MISTAKEN FOR FACIAL NEURALGIA.

A bit of personal experience from the dental side of our profession is always worthy of note by the practicing physician, and the great pity is that the dentists are so reluctant to write for purely medical journals. In the *Med. Rec.*, February 13, 1892, Dr. Charles G. Pease, D. D. S., of New York, published the following timely warning:

I have been induced to write this article for the benefit of my brother general practitioners, owing to the number of cases of pyorrhœa alveolaris accidentally and otherwise falling into my hands, which have been previously diagnosed as facial neuralgia and treated for such, of course without success. It might be well here to consider the pathology and etiology of this disease of the oral cavity. It has been maintained by some that it was of local origin, while others have ascribed it to constitutional causes. Although it is a disease depending almost wholly upon local causes, such as the irritation produced by a salivary and sanguinary calculus—the latter always a resultant of degenerative conditions of mucous crypts surrounding the necks of teeth, insoluble dentifrices, denture clasps, caustic agents, etc.—yet its peculiar manifestations no doubt often depend upon some unfavorable diathesis which enables the local causes to produce more serious effects than might be possible in better systemic conditions. Mercurial medicines should not be forgotten as a cause. The constant irritation produced by salivary calculus, or by other irritants at the necks of teeth, produces an inflammation of the gingivæ, causing them to weep a serous flood from which we get the serumal deposit upon the tooth under the free margin of the gum, this acting as an additional irritant. Simple gingivitis will in this way contribute to the development of the disease. When a slight deposit has taken place it becomes an irritant which will in itself perpetuate the disease. The gum and lower border of the peridental membrane is kept in a state of chronic inflammation, resulting in the continued though very slow increase of the deposit. It may be years before it will be productive of serious conditions. Finally, ulceration of the peridental membrane occurs and it is gradually destroyed. The alveolar wall is absorbed, and a pocket is formed between the root of the tooth and the gum. The serumal calculus is deposited as the root is denuded of the peridental membrane, and so continues in the work of destruction to the very apex of the root, the tooth becomes loose, pus exudes about the neck of the tooth, and the dental organ is finally lost.

During the progress of the disease there are frequently periods of considerable pain, often lasting for weeks or months, simulating facial neuralgia, frequently augmented by food in the pockets undergoing fermentation about the neck of the teeth, making them acutely sensitive. These conditions are too frequently overlooked by the dental surgeon, a large number of cases giving no visual evidence to the unpractised eye of the progressive disease which will finally prove so disastrous, if not properly treated. I will cite several cases.

Miss B—, aged twenty-four, came to my office to consult me upon the subject of her sufferings. She had been treated for neuralgia of the face; her own dentist whom she had consulted for caries of the teeth as a possible cause of the trouble could not find anything in the condition of her mouth indicating a cause, but gave her the comforting assurance that the neuralgia would soon pass away and that he could do nothing for her. She bore the pain for months, it was constantly increasing, and she was not able to rest at night.

On examination I found the condition of which I am superficially treating in this article, over two of her teeth, left superior six and twelve year molars. By

the means of appropriate instruments I removed the accumulation of serumal calculus (hidden from view), to the full extent of the pockets, together with the fermenting food, etc., as well as I could at one sitting. I then applied indicated remedies and made an appointment for another sitting, telling her that I had no doubt of her being able to sleep that night, which prediction she realized with so much pleasure that she could not wait until the next appointment, but wrote me the following morning telling of the complete success of the operation.

Mrs. W—, aged forty-four, brought to me by her physician, had been treated unsuccessfully for facial neuralgia. Her own dentist could not find anything about her mouth as a cause. On examination the same conditions presented about six of her teeth, the gums being badly congested, to all of which I called the attention of her physician. She was placed under my care for the local trouble. The pain diminished markedly under treatment, and entirely disappeared in several days, the tissues returned to their normal condition, and in three weeks the pockets were completely closed.

Mr. S—, aged forty-two, was suffering from one of his frequent attacks of so-called facial neuralgia. I found the majority of the teeth involved; at some points the disease had progressed to a serious degree. He was much surprised when I told him the cause of his trouble, demonstrating it by affording relief. He made the statement that his sister had suffered with the same character of pain, and that, after being treated for facial neuralgia without relief, she had had a number of sound teeth extracted, not knowing what else to do. It will be borne in mind that the tooth itself may be perfectly sound. These cases are but a type of many. If the diagnostician will think to look for this disease as a possible cause in symptoms of facial neuralgia, it may clear up a large number of cases.

BUFFALO AND ITS HEALTH DEPARTMENT.

The revised charter of the City of Buffalo contains numerous provisions in regard to the Board of Health and its duties, some of which may be of interest to those who have not personally examined the new law.

The Board of Health consists of three members, the Mayor, the President of the Board of Public Works, and the Health Commissioner.

The latter holds office for five years and must be a reputable and licensed physician, at least thirty years of age, and having an active experience as a practicing physician of not less than five years.

The Health Commissioner has supervision over the care, removal, burial or incineration of the dead, the registration of births, marriages and deaths, of vital statistics; and with the approval of the Board, may make such rules and regulations as are necessary for the protection of the public health. The city is divided into eight health districts, for each of which a physician in good standing is to be appointed.

He is to have the title of a city physician.

In addition there are to be two homœopathic physicians whose districts are to be designated by the Board.

It is the duty of the city physician to render all necessary medical services to indigent sick persons in their districts, and report to the Board of Health all nuisances or unsanitary places, or any violations of health ordinances which may come under their notice.

The Board of Health has full power to abate nuisances, to take proper measures to prevent the entrance of pestilence or infectious diseases, and to stop persons coming from infected places and remove them to quarantine hospitals. It can disinfect buildings, vessels, clothing, etc., or destroy the same. The plans

of all buildings to hold more than three families, of slaughter houses, livery stables, etc., etc., are to be submitted to the Board. The drainage and plumbing of public or private buildings must be according to plans approved by the Board. It is the duty of the Health Commissioner to visit all hospitals where patients supported by the city are received, at least once a month.—*Buffalo Medical and Surgical Journal.*

TO COLLECT URINE-CASTS RAPIDLY.

At a recent meeting of the New York Pathological Society (*Med. Record*, Feb. 27, 1892), Dr. George C. Freeborn said that at the last meeting of the Congress of Internal Medicine, held at Wiesbaden last April, Dr. Littman, of Berlin, had presented a centrifugal machine adapted for the rapid separation of deposits from fluids for the purpose of microscopical examination. In the machine presented at that time a speed of nine thousand revolutions per minute could be obtained. Dr. Freeborn said that he desired to present to the Society a home-made machine of this description, which, although capable of only about nine hundred and fifty revolutions per minute, had answered admirably the purposes for which it was devised. He had taken the necessary gearing from an ordinary rotary drill, and this combined with a table clamp and a disk of sheet brass attached to the end of the spindle were all the essential parts. To the periphery of the disk of brass a number of wire gauze cylinders are pivoted, so as to hang vertically when the machine was at rest, but when the machine was in rapid motion, they would be thrown outward, just as are the balls of an ordinary steam engine governor. The fluids from which the sediments are to be collected are contained in small glass tubes, conical at the bottom. These tubes are introduced into the gauze cylinders, and the disk is then revolved rapidly. In this way, the sediment is thrown to the bottom of the collecting tubes, and may then be removed from them by means of a long and very slender capillary pipette. In some of Dr. Littman's experiments with urine it was found that by twirling the tube for four minutes, then decanting the urine into another tube, and repeating the process twice, the urine could be rendered absolutely free from sediment. Crystals could of course be very readily collected in this way, and enough casts for diagnostic purposes could be obtained in five minutes with this machine.

In order to demonstrate the action of his machine, Dr. Freeborn employed three different mixtures: one of lime-water holding in suspension very finely divided carbonate of lime, another of blood mixed with normal salt solution, and the third containing water and carmine. Putting the machine into action for about half a minute was sufficient to show an appreciable quantity of sediment at the bottom of the tubes. In ordinary urinary analysis, not only would this new method enable the microscopical examination to be made about twenty-four hours sooner than formerly, but it would effectually prevent the decomposition of casts which was liable to occur when the urine had to stand for many hours in order that the deposit might settle.

A BLUE BABY.

Dr. W. T. Howard, Jr., sends us in reprint form an interesting account of the autopsy of a child who was under the professional care of Dr. L. E. Neale.

The father is a merchant; both parents are healthy. The mother is a multipara, and the delivery was normal. The patient was small and weak, weighing only five and three-quarter pounds at birth, and lived three months and six days. It was quite cyanotic, and was a typical "blue-baby."

On the second day, it was found that the rectum was imperfect. On the third day Dr. L. McLane Tiffany operated successfully for the relief of this, no anæs-

thetic being used. During the operation, the child was held by the heels, its lower extremities, buttocks and abdomen being nearly black, and its chest, head and upper extremities quite blue; its pulse and respiration very rapid.

The operation was followed by marked shock and collapse, with cyanosis, lasting two days. Under stimulation and careful nursing it improved and would be of quite a natural color for a day at a time. It, however, frequently had attacks of cyanosis with collapse. Its pulse was always rapid. Congenital heart disease was naturally suspected, but after careful and repeated examinations no murmur could be detected; an exact diagnosis as to the seat of the disease was not ventured upon. The heart-sounds were loud and clear.

The child gradually wasted and became weak; slight convulsions and cervical opisthotonos were observed. Towards the last, the hydrocephalic cry was heard. In spite of careful attention and nursing, the child gradually sank.

The most important abnormalities found on post-mortem examination were complete atresia of the pulmonary artery at its origin, strong contraction of the right ventricle, presence of but two segments at the right auriculo-ventricular orifice; patency of the foramen ovale and the ductus arteriosus, thickening and retraction of the middle and posterior segments of the aortic valve, hypertrophy of the *right* auricle and the *left* ventricle.

THE TRUE PHYSICIAN.

The *Journal American Medical Association* gives us the following :

A very winsome man, as a surgeon, was Willard Parker, who passed away from a busy life in 1884, generous and benevolent, even to a fault. That is to say, his stream of human kindness he would not stop even if some of it helped to refresh the undeserving. He was wholesome in appearance, bright-eyed and hearty; his mere advent was a blessing to many a despondent sufferer and he seemed to serve as an embodiment of one of his favorite doctrines, that, "after all, health is more interesting than disease, and a more important concern, both to the doctor and the patient." On one occasion he had been called into the country to visit an eminent senator of the United States. Hurrying from the railway station to the home of the patient, he tarried not to be announced, but bounded up stairs, two steps at a time, to be at once welcomed with, "Why, is that you, Dr. Parker? I declare, I feel better already." He was of those who form a living answer to the captious question of the skeptic, when he asked, "And why has not God made health contagious as well as disease?" There are infectious properties of soul—as charity, fortitude, good humor—which react in a saving way upon the corporeal parts of men. Cheerfulness is in some sense a duty imposed upon the practitioner, which, aided by the "light address," the hilaris vultus of Celsus, has the power of inspiring confidence. The impression which it conveys is that the professional man is the possessor of abundant resources and is the master of them.

Medical Items.

The trustees of the Middleton Goldsmith fund have invited Dr. Francis P. Kinnicutt to deliver the lecture this year, on Friday, May 6th.

Dr. B. D. Evans, for five years past first Assistant Physician at Spring Grove Hospital, has been elected Superintendent of the Maryland Asylum and Training School for the Feeble-Minded at Owings Mills.

Dr. A. K. Bond has removed his office and residence to the north-east corner of McCulloh and Biddle Streets.

The Circle of Willis, we learn by a letter from Dr. Frank A. McGuire, is a society that has recently been organized in New York for the purpose of diffusing social ideas among the medical profession, to the exclusion of "shop." The society has twenty members, and is receiving accessions monthly. It will be seen that it is analogous to the Austin Flint Society, of Baltimore, mentioned by us recently.—*N. Y. Med. Jour.*

It appears that one Senator Smith has been introducing at Albany a bill prohibiting all disposition of human bodies except by burial. Knowing the material of which the present legislature is composed, nothing can surprise us, but this special Smith must be even more so, as it were, than the others. Go back to your ash cart, Senator Smith, to your saloon, your tonsorial palace or whatever you ran for a living before you went to Albany, and try not to mortify us. Perhaps the safest way will be for you to consult some educated adult before exposing yourself again.—*Med. Rec.*

The next annual session of the Board of Medical Examiners of North Carolina will be held in Wilmington, beginning on Monday, the 22nd day of May, and remaining in session until all candidates are examined. The examinations are written and oral, and at this session, as we understand, a number of applicants, chosen by lot, will be required to make clinical diagnoses of cases presented to them. We have received numerous letters on the subject, the drift of each enquirer being as to the requirements of the last session of the Board. Letters on this subject should be addressed to the Secretary, Dr. L. J. Picot, Littleton, N. C.

The thirty-ninth Annual meeting of the Medical Society of North Carolina will be held in Wilmington on Tuesday, May 24th. The Wilmington Medical Society has a Committee on Arrangements in working order, and all letters addressed to Dr. Robert D. Jewett, Secretary of the Committee of the Wilmington Medical Society, will be promptly attended to. Those who have papers prepared and preparing for the meeting, will please communicate, without delay, with the Secretary, Dr. J. M. Hays, Oxford. The Committee of Arrangements consists of Drs. Thomas F. Wood, Chairman *ex-officio*; Geo. Gillett Thomas, F. W. Potter, J. C. Shepard, W. J. H. Bellamy, Thos. S. Burbank and R. D. Jewett.

The session of the Medical and Chirurgical Faculty of this week has been an unparalleled success. The attendance has been very gratifying; the program full to overflowing with excellent papers. The great increase of interest in medical matters of public interest is especially gratifying.

At the meeting last night (Wednesday), it was announced that more than 100 new members had already been received. The following physicians were elected members of the Medical Examiners' and Licensing Board in pursuance of the law recently passed: Drs. Samuel T. Earle, Wm. F. Lockwood, of Baltimore; Dr. S. B. Smith, of Frederick; Dr. W. F. Hines, of Chestertown; Dr. James Bordley, of Centreville; Dr. J. McPherson Scott, Hagerstown, and Dr. W.W. Wiley, Cumberland. The following officers for the ensuing year were elected: Dr. L McLane Tiffany, president; Dr. J. W. Chambers and Dr. Jesse W. Downey, vice-presidents; Dr. G. Lane Taneyhill, recording secretary; Dr. Robert T. Wilson, assistant secretary; Dr. Joseph T. Smith, corresponding secretary; Dr. W. B. Canfield, reporting secretary; Dr. W. F. A. Kemp, treasurer. Executive committee, Drs. W. H. Welch, David Streett, P. C. Williams, T. A. Ashby and George H. Rohe. Examining board of the Western Shore, Drs. Wilmer Brinton, J. Edwin Michael, D. W. Cathell, S. K. Merrick, J. D. Blake and B. B. Browne. Examining board for the Eastern Shore, Drs. W. F. Hines, B. W. Goldsborough, Monmonier Rowe, G. E. Dickinson and James Bordley.

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CONTENTS

ORIGINAL ARTICLES.

Notes on the Use of Chloroform, Ergot and the Douche in Obstetric Practice. By L. E. Neale, M. D., Baltimore. 595

A Scientific Cure for Hernia. By Benjamin T. Shumwell, M. D., Philadelphia. . . . 602

An Address. Delivered to the Alumni Association of the University of Maryland School of Medicine. By E. F. Cordell, M. D., Baltimore. 604

SOCIETY REPORTS.

Medical and Surgical Society of Baltimore. Stated Meeting held Thursday, Dec. 24, 1891. Malformations of Rectum and Anus. Stated Meeting held January 14, 1892. Obscure Case of Osteomyelitis. Hæmoglobinuria. . . 606

EDITORIAL.

Advance. 609
The Annual Oration and Banquet. . . 610
Our New Volume. 610

MEDICAL PROGRESS.

Bacteria in Wounds.—Defective Fingers Hereditary.—Case of an Infant of a Woman Enslaved by Opium Dying for Lack of the Narcotic.—Acquired Immunity.—A Point in the Early Diagnosis of Pregnancy. 611

RECOMMENDATIONS OF THERAPEUTIC AGENTS. . 614

MEDICAL ITEMS. 616

Original Articles.

NOTES ON THE USE OF CHLOROFORM, ERGOT AND THE DOUCHE IN OBSTETRIC PRACTICE.*

BY L. E. NEALE, M. D., OF BALTIMORE.

Perhaps this subject needs no excuse for its presentation at such a time and place, for it is certainly sufficiently practical and has hitherto rarely failed to elicit discussion which, after all, is an essential means of harmonizing, promoting and diffusing medical knowledge; the very reason why we are here assembled.

To those of us, however, who may belong rather to the scientific than to the practical class, I feel constrained to announce that I have no theory to advance, no discovery to proclaim, not even any original work to describe. I merely desire to bring before you in plain, concise manner certain points in connection with the subject of this paper which from clinical observation in my own and a limited consultation practice, I am inclined to think, may need a little more agitation and discussion in just such medical societies.

Chloroform.—It is now an undisputed fact that chloroform stands pre-eminently and, *facile princeps, the* anæsthetic in obstetric practice. Hence, I shall speak of no other.

In the first place, I wish to call attention to a fact that has not seemed to me to have been sufficiently well appreciated at the bed-side, viz., that parturient women, although peculiarly resistant to, are not altogether immune against the

*Read before the Medical and Chirurgical Faculty of Maryland, April 26, 1892.

dangers of anæsthetics; but, as can be proven by well authenticated cases, may be killed by their judicious use in medical hands for therapeutic purposes. (See case of Dr. W. K. Harrison: Hirst's System of Obstetrics, Vol. I, p. 160; and case of R. G. Curtin: Trans. Obstet. Soc., of Philadelphia, for Dec. 4, 1879, *et. al.*)

In this connection we must also remember that there is (*a*), a surgical degree of anæsthesia—complete abolition of consciousness—required in obstetrical operations, painful manipulations, etc., and (*b*), an obstetrical degree of anæsthesia or analgesia, said to be required in normal labor cases to mitigate or annul pain.

The following remarks will pertain exclusively to the latter. A great deal has been written for and against the use of chloroform for the relief of pain in natural labor and the subject is still *subjudice*; personally, I am not an advocate of this plan of treatment as a routine or general practice and think I have known it productive of much harm.

Before the Obstetrical Society of Philadelphia, December 4, 1879, Dr. D. Miller Barr strongly advised such use of anæsthetics, and narrated cases of women in partu who, being skilfully placed in the state of analgesia, were by means of suggestions through conversation on the part of the doctor "taken on imaginary rides, excursions on the water, public entertainments, etc., the ideal picture holding complete possession of the patient's mind to the exclusion of the realities of her condition."

The audience was aroused from this beautiful dream by Dr. M. O'Hara thus tersely opening the discussion: "I do not agree in full with Dr. Barr. Many labors are easy and chloroform is too dangerous to use when it is not necessary. Juries do not deal gently with doctors who are sued for malpractice."

I cannot speak in such extremely pertinent language, but I do say, that "while there is no labor without pain, it is not every labor which requires chloroform." Authorities still differ, but I believe the weight of evidence and certainly of personal experience is that such use of chloroform tends to weaken the force of uterine contractions, to prolong the intervals between them, to lengthen the duration of labor, to stop it altogether, to necessitate the too frequent resort to the forceps and other operations, to the occurrence of post-partum hæmorrhage, to fœtal asphyxia, to headache, nausea, the general discomfort and distress of the woman so commonly caused by anæsthetics.

Lusk says: "It seems to me certain that those who use chloroform habitually will find themselves compelled to resort to forceps with somewhat increased frequency." As coming from such a strong advocate of chloroform, this statement deserves more than a passing notice. If the use of chloroform merely for the relief of pain in natural labor has proved by actual experience on the part of the profession and laity to really accomplish all that has been claimed for it, why is the practice not more generally adopted? I can recall no parallel instance of such cruel, inhuman and almost criminal neglect in the annals of medical history! "Except a glow of stimulation and a sense of fulness in the head," the relief of pain precedes every other distinct stage of anæsthesia and is very liable (ex. gr., by "inhaling the anæsthetic when free from pain, and inhaling it too rapidly") to pass into the stage of abolition of consciousness. Comparatively speaking, the latter is more or less fixed and easily maintained, while the former varies with each respiration. Surgical anæsthesia is easily maintained, obstetrical anæsthesia "is a difficult and delicate task, requiring the closest watchfulness and constant attention" (Hirst, Vol. I, p. 657). I am inclined, remember inclined, to regard this point as the very key-note to the whole dispute under consideration; for personal observation at the bed-side has convinced me that this fine distinction is

not observed by all obstetricians and consequently surgical anæsthesia with all its acknowledged dangers and evil results in obstetric practice is often produced where obstetrical anæsthesia is desired.

The favorable influence of chloroform upon the unyielding os and cervix is now largely superseded by that of chloral, and for irregular and spasmodic uterine pain, chloral and morphine may be used to a better advantage. The most masterly review of this subject I have read is that of Dr. R. C. Reeves, in Hirst's System of Obstetrics. He says: "The type of a labor which best shows the benefits of anæsthesia is one in which expulsive power is active and in excess of dilatation, in which the head is crowded through parts not yet prepared for its passage. Carried deeply enough to moderate the violence of these abnormal contractions, chloroform here renders brilliant service.

"Certain conditions of the general nervous system demand chloroform. Some patients are nervous and hysterical, controlled with difficulty, and the commencement of labor is marked by a very considerable excitement. This abnormal condition is soon soothed and quieted down by the administration of an anæsthetic" (Hirst, Vol. II, p. 677-8). According to my own experience, and I believe, as Dr. Reeves has subsequently admitted, the internal use of chloral or the hypodermic injection of morphine with atropia are much safer and better means of relieving this excessive nervous irritability.

In those few cases where obstetrical anæsthesia is really required, it is generally thought that the most favorable time for its production is towards the completion of the first stage of labor, and as the head clears the vulva; the latter often necessitating the surgical degree of anæsthesia.

Given as here indicated, chloroform should be inhaled during the pain; it should be cautiously administered; its effect must be carefully watched; and where a prolonged sedative or analgesic influence is desired it should be preceded by the hypodermatic exhibition of morphia with atropia.

Before leaving this subject, I insist and beg you all to remember that I do not protest against obstetrical anæsthesia under any and all conditions, but merely oppose its general adoption as a regular routine practice for the relief of pain in normal labor cases. I know this is the practice of some; and the best authorities, together with my own personal experience, teach me to believe it is a bad practice, for the reasons hereinbefore indicated.

Ergot.—The next remedy, powerful alike for good and evil, apparently so little understood and certainly often misused or abused, which I shall here briefly consider, is ergot.

I will be sufficiently modest and conservative to say, that perhaps my experience is not yet large enough to proclaim the dogmatic and pessimistic view, to banish ergot altogether from the lying-in room; but I can conscientiously say I have seen more harm than benefit from its use, or, more properly speaking, its abuse, in obstetric practice, and consequently am inclined to think it would be better for the parturient woman had this drug never been.

We all know its action tends to produce a condition of tetanic spasm of the uterus in partu totally different from the regular, intermittent contractions and relaxations of normal labor; that this tetanic state may be caused by frequently repeated small doses as well as larger doses of the drug less frequently administered; for it is the normal physiological action of ergot on the parturient uterus that is an eminently dangerous condition to both child and mother; that when once started its pernicious influence may extend beyond our control; that individual susceptibility to this influence varies greatly, and we can not always tell be-

forehand just when it may occur: that, in a word, the action of the drug, no matter how administered, upon the pregnant and parturient uterus, is uncertain, unreliable, and fraught with possible and uncontrollable dangers.

I am open to contrary conviction, but my experience teaches me to agree with those who maintain that ergot should not be given with the view of exciting uterine contractions to expel child or placenta. I think "it would be safer to give it to no woman in labor!" I have not used quinine as an oxytocic often enough to hold definite views regarding its efficacy when so administered. Playfair says: "It has no power in itself to excite uterine contractions, but simply acts as a general stimulant and promoter of vital energy and functional activity." In tedious labors from sluggish uterine action, he speaks highly of a fifteen-grain dose.

Lusk says: "Ergot should never be exhibited during the first stage of labor;" nor in the second stage "if there be the slightest mechanical obstacle to delivery or if the fœtal head be high up in the pelvic canal." I have frequently administered a drachm of fluid extract of ergot by the mouth just before giving chloroform for a forceps, high or low, operation, and must candidly admit that I never thought it did any particular good or evil: but, as other similar cases did apparently just as well without it and as on general principles I can readily appreciate the harm it might do, I confess I am not impressed with the necessity of resorting to this very common mode of practice in all cases. To rapidly stimulate the parturient uterus to contract I should rely far more upon the proper use of my hand in making external friction; and if the uterus be empty and require stimulating, I trust rather to the hand externally, or the hand or hot water douche internally, as may be indicated, than to the exhibition of ergot, for I know it to be less reliable. This unreliability of the drug when used as a prophylactic against post-partum hæmorrhage is held by many of the best authorities, *no matter how administered*. Nearly all admit that it is better to withold its administration until after the completion of the third stage of labor.

Never rely upon ergot in the treatment of severe post-partum hæmorrhage resulting from atony of the uterus, for its action is too slow and uncertain. Here we must employ other more rapid and powerful oxytocics, ex. gr., the hand, the hot-water douche, etc., and ergot should be given only to retain and continue the state of contraction and retraction we thus produce and so act as a preventive against the recurrence of such hæmorrhage.

I am not in accord with those who give ergot as a regular routine practice after the completion of every case of labor, but think its use should be restricted to those cases in which there is imminent danger of hæmorrhage.

Neither am I in accord with those who employ ergot to aid puerperal uterine involution, or to prevent or to retard puerperal septicæmia.

Dr. T. A. Reamy strongly maintains that "the natural state of the circulation in the uterine wall after the placenta has been delivered can not be reached if the normal intermittent contraction of the uterine muscle is made persistent. Ergot not only closes up the uterus, but likewise interferes with the circulation within the uterus and therefore interferes with the process of involution, and must lay the foundation for sepsis."

With reference to the action of ergot on uterine involution during the puerperium, the careful observations of Blanc on nearly one hundred women, to some of whom the drug was given and to others not, are particularly interesting. "The following conclusions are amply justified by his experiments: Ergotin administered during the first five or ten days of the puerperium, far from exerting a favorable influence on uterine involution, may interfere with the process; an as-

sertion which is open to proof by careful external measurements, combined with internal."

"In secondary puerperal hæmorrhage the drug is efficacious, and the more so the greater the time which has elapsed since delivery."

Pinzani agrees with Blanc that ergot retards involution, and while it may prevent or lessen after-pains, it may also retard, lessen or suppress the secretion of milk. Personally, I am not at all convinced of its imputed advantage in the prevention of after-pains over the manual expression of possible retained coagula or the internal administration of chloral or morphine. How ergot can hinder or prevent septic absorption (either ptomaine or bacteria) by interfering with uterine circulation and possibly locking up the uterus, I can not understand. Practically I have never tried it, and I place such treatment in the same category with that of opium for septic peritonitis, viz.: bad practice.

Far worse do I consider it to dally with that dangerous condition, placenta-prævia, by the use of ergot.

The fact is, I know of but one condition in obstetric practice that really requires the use of ergot, and that is atony of the uterus after the completion of labor, and even here I do not consider it safe to rely entirely upon the uncertain action of this drug, no matter how administered. The usual form of administration is that of the fluid extract—or ergotol—by the mouth, in doses varying with the indication. The hypodermic injection of ergotin gives a more rapid, and as claimed by many, a more reliable result. Considering the results obtained in gynæcological practice from the administration of the aqueous extract in the form of rectal suppository, I have thought it might also be employed in some obstetrical cases where we may desire a long-continued, slow and gradual action of the drug.

Douche.—Antiseptic injections comprise a third remedy which I think I can safely say is doing much harm as well as good in obstetric practice. It is now generally admitted that the parturient woman's greatest safety lies rather in external than in internal antisepsis, *i. e.*, cleanliness of everything brought in contact with her genitalia from without. This important fact is not practically invalidated by Doederlein's interesting observations, which have shown that the female genital canal may contain pathogenic germs. Speaking of the difference between (*a*), normal and (*b*), pathological vaginal secretion, he says: "The first form is characterized chemically by the high acidity of the secretion, anatomically by the occurrence of pavement epithelia and few mucous corpuscles, biologically by the exclusive appearance of bacilli. The second form is characterized by diminished acidity (is at times even virulently alkaline), by pavement epithelia, by cocci of all sorts, and by the disappearance of the bacilli." In other words, he has sought by examination of the vaginal secretion to draw a sharp line of distinction between the healthy and diseased parturient woman, between the one who requires internal disinfection of her genital canal and the one who does not. With the exception of the litmus reaction of the vaginal secretion, I do not see how this scientific distinction is readily practicable at the bed-side, and when I think of the harm that may so easily result from the unnecessary employment of such internal disinfection, I certainly must hesitate in the light of clinical experience to recommend or persist in the use of antiseptic injections upon such apparently slight if not actually questionable indications.

Still more must I hesitate when I remember the extreme difficulty of thoroughly, and at the same time with safety, disinfecting the female genital canal, and possibly the greater difficulty of determining at the bed-side the germs that are pathogenic and those that are not, or the scientific indication for the injection.

Doederlein himself determined that "irrigation with solutions of corrosive sublimate or of carbolic acid did not thoroughly disinfect, used in the strength commensurate with safety; that the coating of the mucous membrane of the vagina with vaseline (or soap) "antagonized the action of the disinfectants: that solutions of bichloride or of carbolic acid rendered the mucous membrane dry and brittle." Before the Tenth International Medical Congress (Berlin 1890), Fritsch, (Breslau) said: "To-day we are all convinced that if a parturient is healthy she must be left alone—at most the external genitals are to be cleansed." In private practice this statement expresses my sentiment exactly, but in hospital practice, especially where students are allowed to "touch" the women, I believe something more should be done. In these brief notes, which are by no means intended as a thorough resumé of the subject, I merely desire to raise a voice of warning against the employment of antiseptic injections, especially in private practice, unless there is some well-defined indication, usually of a clinical character; and particularly to warn against their administration as routine practice in cases of normal labor and puerperium.

Practically by far the most common and greatest danger to the parturient woman lies in the internal examinations, and this danger is rather from an already infected unclean hand than the slight possibility of carrying pathogenic germs from the vagina into the uterus. This is the line of thought that should guide our practice. I cannot deny the possible prophylactic influence of these antiseptic injections in obstetric practice, yet I cannot recall a case of uncomplicated, natural, spontaneous labor in private practice where I thought their use was indicated, ante-partum, partum or post-partum. I am confident that these antiseptic injections, either before, during, or after labor must be rarely required in normal cases in private practice, and I would not countenance their general adoption in all cases, but would restrict their employment to special indications, ex. gr., fœtid discharges, foul, macerated fœtus, after the removal of tampons, the internal examination of known dangerously unclean or incautious attendants and midwives, special intra-uterine manipulation, etc.

I have often thought that the expulsion of the placenta and secundines with blood clots and a considerable quantity of fluid blood, distending and washing as it does the entire genital tract from within outwards, afforded an excellent natural cleansing, that as a rule rendered artificial measures wholly unnecessary in normal cases. Mermann (Mannheim) reports (*Centralb. f. Gyn.*, 1891, No. 20, Abstract in *Amer. Jour. Obst.*, Vol. XXIV., p. 1279), two hundred cases of labor without internal disinfection and without a maternal death. These included twenty-four abnormal cases of various kinds; and one case of removal of macerated fœtus and syphilitic placenta, piecemeal, experienced only mild sapræmia or ptomaine intoxication.

I shall not attempt to throw any disparagement upon the *therapeutic* use of antiseptic injections, for no one can now deny that in their judicious employment we have our strongest means of treating puerperal septicæmia.

It has been claimed that "whatever our theories may be, it is our duty to treat *fever from mental emotion, aseptic fever, puerperal malarial fever, milk fever,* as if they were of septic origin."

I will not say that this is false, but I must admit that my own experience has not convinced me of its truth. Lusk says that a puerperal temperature above 100½° is not necessarily abnormal, and I have certainly seen in a number of cases such a temperature rapidly subside without any antiseptic treatment whatsoever. While admitting that thorough external antisepsis or cleanliness during labor will vastly

lessen the number of cases exhibiting the so-called physiological puerperal temperature wave and the so-called milk fever, I cannot deny that the temperature may rise above normal, 98.6-10F., from various non-septic assignable causes, and rapidly subside without the use of antiseptic injections. I have thought that such cases were often liable to be rather too hastily dubbed "sapræmia."

The best authorities strongly protest against antiseptic (intra-uterine) injections for a simple rise in temperature or unless there be decided indications, ex. gr., fœtid lochia, macerated fœtus, intra-uterine manipulations. Dr. Henry D. Fry came very near losing a patient by peritonitis caused by a hot vaginal injection administered on the eighth puerperal day; Dr. Chamberlain (New York) has twice seen this result; a large number of fatal cases from both vaginal and intra-uterine ante-partum, partum, and post-partum bichloride injections are on record, and Doleris stated that grave results have followed solutions as weak as 1:5000.

In fact, it has been recommended that in the absence of positive evidence of sepsis the irrigation should contain no sublimate, but consist of plain hot water or salt and water. Of course, with scanty, albuminous urine, no mercury should be used. I am not yet convinced, but am strongly inclined to believe that, after all, no antiseptics and especially no bichloride should be used, either in the intra-uterine or vaginal injections, but merely plain hot water or salt and water sterilized by boiling. When the intra-uterine douche is really indicated, all caution against frequent injections and claim that it is better to wash out the uterus once thoroughly and then let it alone.

The treatment of this organ on the same rational principles as other pus-producing cavities has not given satisfactory results.

"The intra-uterine injection is sometimes followed by symptoms precisely similar to those of septic fever.

"Indeed, if antiseptic precautions are used, the necessity for uterine irrigation for sepsis will very rarely exist." Perhaps the bichloride of mercury is more generally adopted than any other antiseptic to-day, yet as we have seen, it may be attended with so many difficulties and dangers in obstetric practice as to justify thorough precautions or *entire abolition*. It is not safe to use a solution stronger than 1:2000 for the vagina, 1:4000 for the uterus; drainage should be free; it is safe to follow its use by that of plain hot water. Garrigues says: "Bichloride is absolutely contra-indicated in anæmia, abortion, kidney disease and diarrhœa." He, with many others, advocates the use of creolin in two per cent. emulsion, and some prefer the addition of mollin. Doederlein claimed that "by rubbing and irrigating with two per cent. solution of creolin the vagina could be freed of germs; the drug possessed none of the disadvantages of the bichloride or of carbolic acid." He now uses a one per cent. solution of lactic acid, which he has found most unfavorable to the development of pathogenic germs. To the following practical points I would invite discussion: 1, The general use of chloroform as an analgesic in normal labor cases. 2, The general use of ergot for other than post-partum atony of the uterus. 3, The general use of the douche as a prophylactic in obstetric practice.

319 W. Monument St.

An Indian journal states that an epidemic of cholera broke out a short time ago among the sharks which infest the Indian Ocean. The bodies of seventeen British seamen, who had died of cholera in the harbor of Bombay, on the hospital ship, were sewn up in weighted canvas bags, taken out to sea, and cast overboard. It is believed that the sharks feasted upon the remains of the dead seamen, and thus became infected.—*Medical Record.*

A SCIENTIFIC CURE FOR HERNIA.†

BY BENJAMIN T. SHIMWELL, M. D.,
Lecturer on Surgery in the Medico-Chirurgical College.

All methods devised for the radical cure of hernia seek to reach their object by obliteration of the canal, and by this plan to retain the protruding gut. This is the treatment of effect, not of cause.

While fully recognizing the comparative frequency of this trouble, we must not overlook the fact that it is in the minority. As we are all subject to the same exciting causes, we should look for some anatomical reason that will explain its occurrence and non-occurrence, and why after operation, where fibrous tissue in apparent quantity existed, return was possible. There must be more than the production, or rather reproduction, of a canal from the abdomen to the scrotum to account for it.

The first thing, then, to consider is, not the inguinal rings or canal, but the intestines, the prime factor in the case.

The intestines are not a tube lying perfectly free in the abdominal cavity to be pushed here or there, making pressure at this or that point. If they were attached but to the pyloric end of the stomach and to the anus, then it could be readily seen how intra-abdominal pressure could possibly rupture any weakened point in the belly wall, with consequent protrusion of the gut. Instead of being so arranged, their position and action are limited by the folding around them of the peritoneum forming the mesentery.

Careful examination of the body in the dead-room fixes a normal relative position for this limiting membrane. Its point of attachment to the parietes begins to the left of the second lumbar vertebra. Its insertion then follows a line obliquely downward and to the right, to attach itself in the right iliac fossa. Its average length is eight inches; an increase above this is an abnormal state, and on this increase in length depends the production of hernia. The examination of numbers of bodies has proved, beyond cavil, that when a normal condition of the mesentery exists, it is impossible to drag the gut into the inguinal or femoral rings.

Is it scientific to say it is chance that prevents the whole human race from having hernia? Also to lay it to the firmness of attachments of the opposing surfaces of the inguinal canal, or the structures that cover a present hernia? The pushing forward of the superimposed layers of tissue and separation of the obliterated canal speak ill for its preventive power. If they are preventive, then the sudden rupture would give us more serious consequences in primary protrusion than experience shows. The canal does not show the after-conditions that follow usually from tearing, which would be excessively marked here if strong union had taken place. Neither subjective or objective symptoms are present. It is coaptation, not union with firm tissue formation.

It is clear to my mind that the normal length of the mesentery is the preventive factor in the non-production of hernia. If not so, then no one would escape. The exigencies of life and our surrounding conditions are such that all of us at times are subjected to violent strains, giving rise to intra-abdominal pressure sufficient to rupture the internal openings, and to allow the gut to enter the canal.

If these assertions are true, then any operation which has been suggested does not prevent, but modifies. Therefore, any procedure seeking to prevent hernia by obliteration of the sac does not cure. The possibility of return exists.

†Read before the Philadelphia County Medical Society, March 9, 1892.

What is the rational treatment? The opening of the abdomen and shortening of the mesentery. The width of the mesentery does not increase in adult life, but the length is liable to.

The opening of the abdomen and shortening of the mesentery may be objected to on the ground of possible risks. The safety of the operation of abdominal section is settled. The shortening of the mesentery offers no objections. It may be said that the blood supply of the intestines may be interfered with. Careful experiments show the reverse.

Further, to prove that perineal inflammatory changes do not affect the blood supply, is instanced in the omentum after diffuse peritonitis. Operations during the acute stage and post-mortems have shown me conclusively the possibility of contraction occurring without strangulation. In every case of acute peritonitis, unless adhesions have taken place, or, in fact, any case where the omentum has been much handled, we always find it drawn up to its gastro-duodenal attachment as a knotted mass. Still its vitality is maintained. Also, the invaginated mesentery into the divided bowel, in the operation of intestinal anastomosis, does not lose its vitality by contraction and inflammation. Here there is not only change by contraction due to the invagination, but also thickening from the inflammatory products thrown in and about its attachment. That this portion of the mesentery still supplies the bowel with blood is proven by a number of experiments I made, to show that division of the mesentery at the point of invagination caused gangrene. This proves that though changed in its structure pathologically, it does not interfere with its nutritive function as a carrier of blood.

It is understood that the value of an operation lies as much in its freedom from risks as in its ability to maintain its advantages when successful. The freedom from risk has been one of the so-called advantages claimed for the radical cure suggested. Can this be truly said of these methods? It is not always in the province of any operator to say when the operation is finished that he has not divided the spermatic duct. This is not recognized in unilateral operations, providing the other organ duct is permeable, but if not, or if in any subsequent time inflammatory change takes place, it is plainly seen the disadvantages that would arise. There is also the possible atrophy of the testicle from injury to its nerve-supply. Then, again, sharp attacks of peritonitis have occurred, with subsequent changes. There is a law of serous cavities that is definite: "Any inflammation, unless limited by adhesive contact, is diffused over the whole surface." This will hold as good here as in an operation done through section.

The longest part of the mesentery is usually confined to about five feet of the bowel included in a space beginning at a point six feet from the duodenum. If this is above the average length it is apt to hang into the pelvis, and is, in all probability, the portion protruded. It is but reasonable to suppose it is the same loop that is recurrent in its extrusion. There would be no difficulty in locating this portion, as the hernia would be present.

The shortening is done by folding the mesentery over on itself, and holding it in this position by interrupted sutures. The intestine can be delivered, folded, sutured, and then replaced, and successive portions so operated upon. This is a step that of necessity requires expertness in handling the intestine that is only got by practice. The delicacy of the mesenteric tissue is understood. The union of the attached surfaces is rapid, and having been so shortened, there is no possibility of relengthening. Experiments, operations, and post-mortems in cases which had peritonitis, show persistent shortening of the mesentery, the intestines being drawn nearer the spine.

The operation can be made perfectly aseptic, obviating risks. The bowel is not injured. It is done quickly, closure is made, and the patient out of bed in a few days.

AN ADDRESS, DELIVERED TO THE ALUMNI ASSOCIATION OF THE UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE.*

BY E. F. CORDELL, M. D., OF BALTIMORE.

I feel very much honored, sir, in being called upon to speak to this toast, and thus, in some sense, to act as the representative of this meeting and of all our fellow alumni who are absent from us to-night—absent in person only, let us hope!

It would be an interesting procedure, if we were able to feel the pulse, so to speak, of these many hundreds, or rather thousands, of alumni, present and absent, and learn how it is beating, to-night, with reference to that institution just over there. Is it, do you suppose, a pulse of sympathy and unison, or one of indifference and possibly to some extent of bitter hostility? I fear that we should find representatives of both. Men are so differently constituted in this world, sir, that we cannot expect them all to feel alike, or to set before themselves the same ideal of life. But there are certain things that no high-minded or honorable man can ever forget. One of these is the Alma Mater which has trained us and given us our start in life. The debt we owe to her is not one that can be paid by money alone, or that ceases at our separation from her.

Of the deep interest and hearty good-will towards this university felt by many of our alumni—even those whose interests are now centred in other and sometimes rival institutions, we have many proofs; but why, may it be asked, has the feeling not been more general and more demonstrative? Why, for instance, has it not taken the form of endowments and gifts as it has done and is continually doing in the case of so many other institutions throughout the wide land? I will venture to give some reasons.

In the first place, I may remind you, of what you all know, that this community has but lately awakened to a realization of the demands of modern medical education, and of the expense which will have to be incurred in meeting these demands. In the system that has prevailed here, practically up to the present time, we have been satisfied that our graduates should be taught by simple didactic and clinical lectures, with a few dissections, substantially, such as have satisfied our forefathers for a long period back. We are just being roused—somewhat reluctantly, shall I say, and with much irritation—from our long lethargy, and in the consciousness that a new life has dawned in medical education, we find, to our dismay, that we have not been baptized with the water of regeneration to enable us to lead that life—in other words, we have not the pecuniary resources to provide adequately for the new requirements. Now, a full realization of our needs must precede any efforts to provide for them. Perhaps the facts have not been properly presented to those who have the will and desire to help, or to those whose will and desire might be aroused. Has any formal appeal been made, setting forth in detail the directions in which help is most needed, and the methods by which it may most efficiently be rendered? Has any plan been formulated, and has the legal security been arranged for the proper disbursal of large sums of money contributed? In other words, has every one due assurance that donations towards a general or special endowment would be secure against loss or

*Delivered at the Annual Banquet, held April 14th, 1892.

perversion to uses not intended? I cannot conceive, sir, that the many endowments and gifts elsewhere, of which I hear and read continually, have been secured simply by a consciousness of their need on the part of the donor, and without some effort being made by those interested. Indeed, I know in many cases that the contrary is the case. Why do we hesitate to adopt the same means for securing them for this institution? Are our needs any less than those of the colleges which have been their fortunate recipients?

Another circumstance calculated to lessen the interest and dampen the *esprit de corps* of our graduates has been the short time required in study. The period allotted and the crowded curriculum have left little or no time for the birth and development of local attachments and social ties. Two crowded sessions of five, or at most six months, have had all to be given to lectures and study, to render possible even a passable showing, and to reach the goal of our efforts—graduation. Social gatherings have been almost unknown, opportunities for meeting our teachers outside the lecture-room and for the formation of those friendships—often life-long in duration—that take their origin at this time have, only with the rarest exceptions, existed. Many can, I am sure, recall but a dreary and cheerless period of student life, in which there was but little mixture of sentiment, and scarcely any of those associations which linger forever in the mind, and come back to us through after-years with increasing pleasure with the lapse of time. I am not saying, sir, that this has been an experience limited to this place; it was the fault of our system and prevailed widely, although it was intensified here and doubtless elsewhere by the want of those academic surroundings which belong to a university in which all the departments are fully equipped and in working order.

In view of these circumstances, we may be thankful that there exist those who will cherish this University as a dear and honored friend to whom they owe much —very much—and whose pulse quickens with joy at any tidings of her welfare and advancement. It is all the more to their honor that no drawbacks such as I have named have dampened their ardor or attachment.

But, Mr. Chairman, there is need of action on our part and no friend of the University must longer be idle. The need is too urgent to be delayed. We must all consider our duty in the premises and be prepared to give more than sympathy and mere words of cheer. I will not, for one, despair, sir, of the ability and willingness of our alumni to do for this institution, what the alumni of many other institutions, many of less age, renown and merit, are doing with so much zeal for theirs, until an earnest and well-directed effort has been made to enlist their interest and failed; and I have such confidence, sir, in the integrity of human nature as to feel assured that success is not only possible but highly probable. And what a noble work it will be to contribute to the resources for carrying on the most advanced methods of instruction here, and how it will encourage the minds and stimulate the efforts of those who for the time being are entrusted with the conduct of affairs. These gentlemen are endeavoring, to the best of their ability and their limited means, to introduce reforms and maintain the ancient reputation and renown of this University, handed down to them from their and our forefathers, and shall we give them no helping hand? Let us each and every one constitute himself a special agent and pleader for the propagation of this idea, the vital idea in all medical reform, the true solution of the problem of medical education, the only means by which this University can recover its waning laurels and prestige and maintain a leading position in the pregnant future!

Society Reports.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING HELD THURSDAY, DECEMBER 24, 1891.

The 733rd regular meeting was called to order by Vice-President Dr. J. F. Martenet. The minutes of the previous meeting were read and approved.

Dr. J. F. Martenet read a paper entitled MALFORMATIONS OF THE RECTUM AND ANUS. (See JOURNAL of April 2, 1892). Discussion.

Dr. J. Wm. Funck: A few months ago I delivered a lady of a large, fine-looking female child and on the day after its birth the nurse called my attention to an absence of the anus. At the usual site of the anus there was a slight depression and in the centre of this depression was a very slight tit-like elevation, but no opening whatever. Bimanual examination, the palm of one hand pressing firmly over the abdomen, one finger of the other hand in the anal depression, no impulse could be obtained. The child took nourishment normally, even greedily. The abdomen became tensely distended and the child vomited undigested milk and meconium. On the morning of the day on which it died, if it were held with its head elevated it breathed all right though rapidly and it was evidently suffering considerable pain from the external distension, but if it were laid with its head low, the contents of the stomach, mixed with meconium, would be ejected from the nose and mouth without an effort; so freely, in fact, that it seemed to be in danger of suffocation from this cause. I had Dr. Michael see it with me and he decided that the only operation advisable was to make an opening in the left groin. This was declined by the parents, and the child died in 72 hours after birth. I secured a post-mortem, but was hampered considerably by the father's presence, which made the post-mortem less satisfactory than was to be desired. The bowel ended suddenly in a much-distended blind pouch at about the promontory of the sacrum. In the light which Dr. Martenet has thrown on this subject, I would say that my case would be one of the 8th class as enumerated in his paper, one in which there was a total absence of the rectum.

Dr. D. W. Cathell: In a practice of over 20 years, I have not had a case of my own, but have heard of several, all of whom died but one, and that was a girl who had attained her 5th year when her case came to my knowledge. Three years after this I heard that she passed all her feces per vaginam. She was operated on, but died shortly after.

Dr. David Streett: I have never delivered a child of this kind. I saw one, a colored male, who passed its feces by the urethra and who strained and cried a good deal at each passage. It was diagnosed as one in which the bowel opened into the bladder. Operation was declined in this case and the child died at five months. We all know that this condition is due to non-development more or less marked at an early fœtal period and the only treatment that is applicable to it is surgical treatment.

STATED MEETING HELD THURSDAY JANUARY 14, 1892.

The 734th regular meeting of the society was called to order by Vice-President Dr. J. F. Martenet.

The minutes of the previous meeting were read and approved.

The following gentlemen were elected to membership: Dr. L. Gibbons Smart, Dr. Lewis F. Frey, Dr. Wm. T. Howard, Jr., Dr. J. Mason Hundley, Dr. Joseph Gichner and Dr. R. H. P. Ellis.

Dr. S. T. Earle reported AN OBSCURE CASE OF OSTEOMYELITIS.—I saw the case with Dr. Ingle who had diagnosed it as acute rheumatism, he gave the patient,

(a boy of 14) salicylate of soda in 15 grain doses, for several days. The symptoms abated and the temperature fell to normal. The epistaxis and tympanitis developed and these in connection with delirium, which he had had from the first, lead me to suspect it a case of typhoid fever. Dr. Ingle thought it a case of meningitis. There was some enlargement in the right iliac region which made another doctor think it a case of typhlitis. The boy died that night and Dr. Chambers made a post-mortem examination. The spleen, kidneys, liver and lungs were all normal, the brain was found hyperæmic, and Dr. Chambers made the remark that the brain looked as though the patient had died from septic poison. He had had a sore on the ankle which had all scabbed over and seemed to be in a healthy condition, and when the periosteum over the tibia was cut through there was found an abscess. His mother had a cancer of the rectum and she dressed the boy's leg. Could this have been the source of infection? It is a case that would mislead almost any practitioner; the initial symptoms of acute pain from the knee down and a temperature of 104° pointed to acute rheumatism. The tympanitis and delirium then pointed to typhoid fever and then there were symptoms which made Dr. Ingle suspect meningitis. There was no localized point of special redness or tenderness over the limb.

Dr. W. S. Gardner: I saw a case in the city hospital where pus was found in the joints without there being any special redness at any point.

Dr. F. C. Bressler: In my case reported to the society several weeks ago, I said that if you have a child with rapid pulse, high temperature, 104 or thereabout, and marked delirium, etc., after you had excluded other causes then examine the junction of the epiphysis with the diaphysis and you will most likely find a tender spot. The case that Dr. Earle reports lends emphasis to what I then said. The source of infection cannot always be detected. The diagnosis is generally difficult to make. I know of a case of a man who was shoved out of a saloon; when he got home he was sick and his doctor treated him for pneumonia. The post mortem showed a number of miliary abscesses in the left lung, while there were none in the right lung, and a large accumulation of pus in the knee joint. The symptom of tenderness of the limb in Dr. Earle's case was doubtless most marked at the upper part, at the junction of the epiphysis and diaphysis.

Dr. C. Hampson Jones: In reference to acute symptoms in inflammation of bone. A woman had been delivered some time before admission in the hospital. She had been been in two days before I saw her and her fever chart showed a typical double tertian ague temperature. There was no malarial fever in her neighborhood. The doctor who had her in charge said he thought it was due to periostitis. Close examination showed no special tender spot or localized redness and that diagnosis had to be given up. The post-mortem in her case revealed a periostitis of the pubic bones, doubtless caused by some manipulation during her delivery.

Dr. J. F. Martenet: I have been struck by the enlargement of the lymphatic glands on the limbs of young people and have found them almost invariably associated with abrasions or acute ulcers on the limbs. This has been noticeable in quite a number of children that were brought in the dispensary on account of indefinite symptoms—intermittent fever, restlessness, crying, etc.—who had been attended by physicians who had not examined them very carefully. We find, in quite a number of these cases, that the joints are tender, and there is more or less sensitiveness of the bony structure. One case, a child seven days old, was brought in with constant crying and retraction of its legs. I gave it something to correct its digestion, but there seemed to be something else that needed treatment. I put it on increasing doses of iodide of potash until it was

taking three grains, then I gave it 1-120 grain of bichloride of mercury and it recovered promptly.

Dr. David Streett read a paper entitled HÆMOGLOBINURIA. See JOURNAL, January 30, 1892. DISCUSSION.

Dr. F. C. Bressler: Hæmaglobinuria is not so common in this climate. The difficulty in making a diagnosis without the aid of the microscope causes a certain number of cases to be unrecognized. The only positive symptom being the absence of red corpuscles, which can only be ascertained by the microscope.

Dr. David Streett: It often occurs in a mild form and the patient recovers without its being diagnosed. Some cases which we put down as malaria are, doubtless, cases of hæmoglobinuria. I was led to look up this subject by seeing a specimen of urine that was characteristic of this disease, red and bloody-looking, but on finding no red corpuscles my interest was awakened. About six years ago, Dr. Jacobi, of New York, wrote a paper in which he reported the destructive influence on the red blood cells of chlorate of potash, given in large doses in diphtheria, producing hæmoglobinæmia, thus causing hæmoglobinuria. I have been cautious of the use of chlorate of potash since that time. Many writers claim that these cases are due to infection, some from syphilis, scarlet fever, etc. I do not know that it has any special organism as yet.

Dr. J. F. Martenet: I think it is the opinion of Dr. Welch that there is an organism that sets up these troubles in the kidneys, but it has not yet been definitely determined.

1710 W. Fayette St. J. WM. FUNCK, Rec. Sec'y.

ABSENCE OF THE VAGINA.

At a recent meeting of the North of England Obstetrical and Gynæcological Society (*Brit. Med. Jour.*, April 2, 1892), Dr. M. Campbell narrated the case of a girl, aged 14 years and 10 months, who had never menstruated. There was abdominal pain and swelling, the pain at first, for about a year, being intermittent, but for the last two weeks constant. On examination there was no vaginal opening to be seen; rectal examination revealed a cystic swelling lying between the rectum and the bladder. After the bladder had been emptied an opening was made by means of scissors between the urethra and rectum, and after dissecting nearly two inches the bulging sac was reached. This was opened with a bistoury, a grooved needle having first demonstrated the contents. The opening was dilated with dressing forceps, and dark treacly fluid evacuated. The patient was douched regularly with 1 in 3000 sublimate solution, and made a good recovery. Hegar's dilators were used regularly in the after-treatment, to keep the newly-made opening pervious.—Dr. Rawdon narrated a similar case, where the menstrual fluid had been evacuated *per rectum*.—Dr. Wallace related two cases of imperforate hymen in sisters.

The Ohio Legislature has recently passed a law providing that physicians in the discharge of professional duties shall be permitted to ride, at their own risk, upon freight trains between stations where such trains stop, paying therefore the regular passenger fare.—*Med. Rec.*

The President has appointed John Mills Browne, to be Surgeon-General and Chief of the Bureau of Medicine and Surgery in the Navy, with the rank of Commodore.

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A. K. BOND, M. D., Editor.

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BALTIMORE, MAY 7, 1892.

Editorial.

ADVANCE.

The signs of the times indicate a general awakening in the medical profession of Maryland, to the needs of improvements in several particulars.

The establishment of the Johns Hopkins Hospital in our midst has not only brought into the State a large force of eminent workers and teachers, but has also quickened the interest of our home workers in the more scientific side of medicine. We hope that at an early date this great institution will become thoroughly amalgamated with the profession of the State; so that, while still preserving its individuality and high standard of work, it may lose every mark of foreign importation. Certain of its teachers have already won the friendship of the State profession by the earnest and unassuming manner in which they have thrown themselves into the work of home institutions. Of none is this more true than of the retiring President of the State Faculty, Dr. Wm. H. Welch, whose instructive address we hope to publish in a future column.

THE NEW MEDICAL LAW

marks an advance in the history of medicine in Maryland; although our pride is somewhat damped when we reflect that even this is but a partial return to the high vantage ground which was held in the earliest days of the Faculty's existence. Still, in view of the fact that the difficulties in the way of securing ideal legislation in medical matters are much greater now than formerly, there is good reason for congratulation.

The stimulus attaching to

THE ELECTION OF THE STATE EXAMINING BOARD

is credited with much of the increase of interest which medical men have shown in thework of the Faculty. A very large accession of new members has been received—some 130 in all.

THE FINANCIAL POLICY

of the Faculty shows wisdom, in that it has determined to clear itself of debt and

to keep its expenses within its income at all hazards. It is to be hoped that the transactions for the present year will still be large enough to present a creditable appearance: even if many papers are to be left out for the want of space. It would be better to preserve the series of Transactions unbroken, even if minor papers had to be omitted during several years. The presence of a very thin, mean-looking pamphlet in a series of handsome volumes is a disfigurement that can never be remedied.

We believe that the action of the Faculty in petitioning the Mayor and City Council, through a special committee, for sanitary improvements, is well taken.

Already we observe that a certain firm of itinerating advertising doctors announces that it is about to leave the city. It is to be hoped that others will anticipate the action of the State law in like manner.

All thanks to the physicians who with great self-denial have, laboring day and night, made this annual session of the Faculty a unprecedented success.

THE ANNUAL ORATION AND BANQUET.

On Thursday evening a large audience assembled in the Hall of Faculty to hear the address of Dr. Lange, of New York City, on "The Pathology and Treatment of Acute Spontaneous Osteo-Myelitis;" a subject upon which he is an acknowledged authority. The address was both scientific and practical, and was illustrated by beautifully prepared specimens of diseased bones. This is the first annual oration on a surgical subject delivered before the Faculty, at least for many years, and it was highly appreciated by the physicians and surgeons assembled.

After the delivery of the oration, the gentlemen present devoted themselves to social intercourse and to the discussion of a well-served banquet. The country members were, as usual, guests of the Faculty.

OUR NEW VOLUME.

With the issue of last week we entered upon a new volume of the JOURNAL; celebrating that event by a change of paper to a whiter tint. For the present the single column will be retained. Some of our subscribers desire a return to the old form of double column, while others prefer the single column. There are perhaps a few very rapid readers who read by lines, taking in the whole line at a time; for these a double column is undoubtedly more desirable. We believe, however, that the great majority of our subscribers read by words, running the eyes along the line from left to right; by these the single column will be preferred, as there are but half as many lines to the page. Personally, we prefer the single column, as presenting a neater appearance.

In the new volume it will be our aim to present to our readers the minutes and as many as possible of the papers of the annual session of the Faculty, including the addresses and the oration, which have been solicited but are not yet in form for the press.

We hope to present also a column of epitomized translations from foreign journals by a new collaborator.

Original articles will be solicited from the best workers in our own and in sister States.

In the "Medical Progress" column will be given original abstracts from original articles in domestic and foreign journals. The leading journals are now so numerous and so bulky that the practitioner cannot afford the money and the time to keep up with them all. Our purpose is to present in a condensed form the important facts brought out weekly in the whole field.

Our column of "Items" needs improvement. As we cannot know all the minor events of medical interest in the State, we will be grateful if our subscribers will jot down such items on a postal card when they occur and mail it to us. We will gladly make a note of the information thus received, with or without the publication of the sender's name, as he may prefer.

Medical Progress.

BACTERIA IN WOUNDS.

In the *Johns Hopkins Hospital Bulletin* No. 21, Drs. Robb and Ghrisky write: From our observations we feel justified in drawing the following conclusions:

A wound at some time of its existence always contains organisms. They occur either on the stitches or in the secretions.

The number of bacteria is influenced by the constricting action of the ligatures or drainage tube, or anything interfering with the circulation of the tissues.

The virulence of the organisms present will influence the progress of the wound.

The body temperature is invariably elevated if the bacteria are virulent; and, indeed, in cases where many of the less virulent organisms are found, almost without exception, there is some rise of temperature.

Different suture materials offer different opportunities for bacterial development. The catgut suture would seem to be the best adapted to their growth. In the event of the presence of the streptococcus pyogenes or staphylococcus pyogenes aureus infection, such cases should be isolated as far as possible, to prevent the infection of subsequent cases, which almost invariably follows where isolation is not practiced.

Undue constriction of the tissue by ligatures must be avoided, if the tissues are expected to resist bacterial invasion.

Such bacteriological examinations as we have just reported teach us the importance of securing an aseptic field of work and technique, as the introduction of a virulent organism under the above circumstances would be productive of great harm.

We have no sure and absolute method of rendering the field of operation entirely free from organisms, owing to the impracticability of destroying them in the superficial layers of the skin. The staphylococcus epidermidis albus (skin coccus) is found in the skin with such regularity that the latter situation may, for all practical purposes, be regarded as its natural habitat; and our methods are not successful in reaching those bacteria in the depth of this structure.

It has been proven that the use of permanganate of potassium and oxalic acid in disinfecting the skin reduces the danger of infection from this source to a minimum.

DEFECTIVE FINGERS HEREDITARY.

Writing in the *Lancet*, February 27, 1892, Dr. R. C. Lucas, of Guy's Hospital, says:

To return to the crooked little finger. I was examinining a man for insurance on November 14th, 1891, when I noticed as he presented his hand that the little finger was crooked and short. I asked if there was not others of his family with the same defect, and he replied that his fourth child, a son, had precisely similar little fingers. I pressed him further for his family history as to any similar defects, and after some hesitation on his part I procured the following account. His father and mother he believed to have been perfect, and he knew nothing of their ancestors. His father married twice, and his two half brothers had on each hand the second finger shorter than the third; or, as he put it, the second and third fingers had changed places. His eldest daughter and second child was born with no fingers on the right hand and a small thumb. One half brother only is married, and he has one child unmarked. I have already alluded to my patient's fourth child having his father's peculiar little fingers. One of his father's brothers married his mother's sister, and they had five children, one of whom, a daughter, is married and has an only daughter with a thumb absent on the right hand. Another of his paternal uncles is married, and has a family. His eldest daughter, first cousin to my patient, is married and has three children, of whom the eldest, a boy, has no fingers on the left hand. In this family there is shown to be a peculiar tendency to a shortening or disappearance by suppression in development of particular digits, and it is the first instance I have come across which would seem to indicate that shortened crooked little fingers may lie in close proximity to the more serious deformity of further suppression of other digits. It was the observation of the peculiar little finger that led me to obtain the extraordinary history just detailed. It is now well established that a tendency to the production of supernumerary digits is strongly hereditary, but there is less accumulated evidence as to a like hereditary proclivity in the case of suppression of fingers or toes. It would seem that nature, having arrived at a tendency to suppression in a particular individual—of which the earliest indication may be a shortened or bent finger—in some of his descendants may sweep away wholesale the fingers of a hand. There is an obvious reason why there should be less opportunity of establishment heredity in cases of suppression than in super-abundance, because in the former the loss is apparent, and is classed by the general public as a deformity to be avoided; whereas supernumerary digits are usually removed by surgeons during infancy, and thus the tendency is concealed.

CASE OF AN INFANT OF A WOMAN ENSLAVED BY OPIUM DYING FOR LACK OF THE NARCOTIC.

Dr. J. M. Hays writes as follows to the *North Carolina Medical Journal*:

Anent the paragraph in the current number of the *Journal* from Dr. Wood's Therapeutics, in which he states that the new-born children of opium-eating mothers are prone to die within forty-eight hours for want of their nerve stimulant, I report the following case:

Sylvia P., æt. about 40, a respectable colored woman, gave birth to her first child September 18th, 1886. Sylvia had for many years been a great sufferer from vaginismus, and consumed large quantities of morphine daily. The late Dr. P. W. Young had several years previously removed her coccyx, and the labor, though slow, was uneventful. The child was well developed and all promised to go well. On the next day the child died in a state of collapse preceded by hæmatemesis. I studied the case very carefully at the time, but the authorities

to which I had access were all very vague in giving the etiology of hæmorrhage from the stomach in new-born infants. I reached the independent conclusion that the cause of death in this case was the sudden withdrawal of the morphine which had become an essential element in the blood of the child during its intra-uterine life. I am now more than ever convinced that this was the proper solution of the problem. Under similar circumstances I would in the future not wait for serious symptoms to develop in the child, but immediately after birth institute a course of treatment for the opium habit, based upon the quantity of the drug used by the mother. If the mother's normal weight was 120 pounds and the quantity of morphine consumed by her in twenty-four hours 8 grains, the proportion going to the child just before birth would be about ½ grain for the twenty-four hours. This I should give (making out the proportions in each individual case, of course) with a gradual diminuition in quantity until danger is past. I believe the hypodermic method of administration should be used—a method not fully appreciated and far too little used in the treatment of children's diseases.

In connection with the case just reported I will say that parturition cured the vaginismus of so many year's standing, and I think Sylvia has never taken any form of opium since that day.

ACQUIRED IMMUNITY.

In an article upon the mechanism of immunity, (*Medical News*, April 23), Dr. B. K. Rachford, of Cincinnati, gives his reason for believing the following propositions:

1. All self-limited parasitic diseases confer immunity.

2. In the local parasitic diseases, the completeness of the immunity, and the length of the period of immunity, will be in direct proportion to the severity of the constitutional symptoms of the attack that conferred the immunity. In this class of diseases, retained chemical products produced by the cells are the chief factors in conferring the immunity.

3. In the general parasitic diseases in animals of like susceptibility, the completeness of the immunity and the length of the period of immunity will be in direct proportion to the severity of the attack that conferred the immunity. In this class of diseases, acquired cell-function is the chief factor in conferring the immunity. Immunity from this cause is more or less lasting.

A POINT IN THE EARLY DIAGNOSIS OF PREGNANCY.

At a recent Society discussion of this subject in the Kings County Medical Society, Dr. Skene said:

Another sign is the peculiar secretion in the cervix. There is a difference between the secretion in the cervix of the pregnant uterus and that of any other pathological condition. In the pregnant uterus the cervical secretion has a whitish, opaque appearance, that at first sight is very much like the leucorrheal discharge in a case of muco-purulent cervical endometritis; but careful examination proves that it is not, because it contains pus, which gives the opaque appearance, while in pregnancy opacity is due to the coagulation of the albumen by the secretions of the vagina. That is characteristic of pregnancy, and occurs in no pathological condition, and is almost always present. When I find that opaque secretion of the cervix, that peculiar hue of the cervix and vagina, and the other physical signs, I am more positive of the diagnosis in the early months of pregnancy, than in the fourth or fifth month, when fœtal motion is present, but on account of a fatty abdomen, is hard to distinguish.

Recommendations of Therapeutic Agents.

In the *Journal of Mental Science* for the current month, Dr. Carlyle Johnstone records his observations on the effects of sulfonal, on fifty patients, suffering from various kinds of mental disorders, including general paralysis, melancholia, and mania. His experiences with the drug point to the conclusions that in properly regulated doses, it is an efficient hypnotic, and compared with that of other hypnotics, its action is fairly certain and constant. The sleep produced by it is natural, and undisturbed by dreams; it had no injurious effect upon the appetite, circulation, respiration or temperature, and the general health does not suffer under its use. After a time, the dose may be reduced or it may be discontinued, and the patient still continue to sleep well. Dr. Johnstone also found that it had a distinct sedative action in mental excitement and distress, and could be employed with great benefit in cases of insanity, especially such as are of recent or acute character. Its complete tastelessness also is recommended in such cases, allowing its combination in food, or in milk, in such a way as to escape the notice of the patient. The chief drawbacks were found to be its slowness of action, and often the persistence of its soporific effect, during the succeeding day, together with, at times, confusion, giddiness and fatigue. After repeated doses, a dreary confusion was noticeable, and subsequently, slight weariness and fatigue, followed in a few days by weariness and shakiness of motion, but nothing occurred which could be called an alarming symptom. As a rule, indeed, the mental condition improved, the excitement, irritability and motor restlessness being diminished and the wretchedness dispelled. It will thus be seen that the writer's conclusions are in accordance with the majority of those already published, and that while regarding sulfonal as by no means a perfect hypnotic, he is inclined to give it a very important place in the treatment of sleeplessness and restlessness generally. The best doses he found to be between thirty and forty grains, and it should be given just before the patient lies down. The freedom of the drug from taste or smell, as has been said, is one of its advantages, and renders its administration easy.—*Lancet*, January 23, 1892.

The unexampled success of phenacetine as a certain and safe antipyretic, has given rise to many clinical comparisons of that medicament with other febrifuges but their results have served only to increase the reputation of phenacetine. Professor Eickhorst; of Zurich, recently said (*Schweizer-Aerste*, No. 5, 1892). "I have no great partiality for new antipyretics, for, in my opinion, fever should only be combatted in emergency cases, and for this purpose some of the known antipyretics are amply sufficient. But if I should happen to find an antifebrile treatment necessary, I should certainly make use of phenacetine. Phenocoll is an active antipyretic, but under its influence most of my patients perspired very profusely, and several suffered from rigors. The temperature soon rose again, and I found that the action of phenocoll did not in any give so satisfactory an action as that obtained from phenacetine."

As an anti-rheumatic, phenocoll does not equal salicylic acid and as an anti-neuralgic, it has not as yet proven particularly favorable, but it has been noticed that abdominal typhoid seems to take an easier course after its administration.

The Hungarian State Health Commissioner, in a report to the Minister of the Interior (*Pharm. Post*, Vienna, No. 10, 1892) stated that in the treatment of influenza, no specific was known but each case required individual treatment.

Concerning the use of antipyretics, such as antipyrine and phenacetine, it appeared that the latter especially gave good results, while a portion of the patients were less favorably affected by salipyrine.

Medical Items.

A new medical college for women is to be established in St. Paul, Minn.

Dr. W. Guy Townsend, late Resident Physician at the Maryland General Hospital, was married Wednesday evening, May 4th; and will open offices at 412 W. Biddle St.

One of the best remedies for sprains is the application of hot water as hot as can be borne, repeated frequently; the addition of chloride of sodium to the water is beneficial. Tradition requires that the hot water be poured upon the sprained part from the height of about 12 inches.

Copies of the "Medical Law," recently passed by the Legislature to regulate the practice of medicine in the State of Maryland, may be had at the office of the Journal Publishing Co., 209 Park Ave., at 10 cents per copy. Enclose stamps or currency.

We read with deep regret as this is going to press, the announcement of the death, in his 42nd year, of Dr. John VanBibber, a well known specialist in nervous diseases, of this city, and author of many contributions to our journalistic literature. We tender to his father and brother our sincerest sympathy in their bereavement.

Malnutrition is the key-note to many disorders of childhood. Not only such obvious forms of malnutrition as the marasmus of diarrhœa, and the wasting of phthisis, should be noted, but also rickets in its frequently overlooked incipient forms, scurvy, and a host of troubles characterized by anæmia, flabbiness, inactivity, chorea, sweating and other neuroses should receive attention. Most of these yield to proper dietetic measures.—*Jour. Am. Med. Asso.*

The organization of the Pittsburg Medical Library Association has been completed, and the prospects for the success of the effort are most flattering. The officers are: President, Dr. W. S. Foster; Treasurer, Dr. R. W. Stuart; Secretary, Dr. A. S. Daggette; Library Committee, Drs. T. D. Davis, J. C. Lange, J. A. Lippincott, W. R. Mercur, E. G. Watson and J. C. Hierholzer, with the president, treasurer and secretary members *ex-officio*. Applications for membership may be made to any member of the library committee, and every regular physician in good standing in Allegheny county is eligible. The address of the association is 76 Sixth Avenue, Pittsburgh.—*Pittsburgh Med. Rev.*

The sanctity of a jury-room appears to be so well guarded that even in case of sudden sickness, a physician may not enter except after due process of law. In the Foss will case, tried recently in Boston, the jury was deliberating, when late in the evening, one of them was suddenly attacked with what proved to be a stroke of apoplexy. The officer in charge notified the deputy sheriff, who, not having authority to let any one into the jury room, drove across the city and informed the sheriff, but even this official was not high enough to act, and another expedition started in search of the judge. As the latter happened to be at home, the requisite order was obtained to summon a doctor.—*Boston Med. and Surg. Jour.*

There is no surer test of a physician's nature and the gentlemanly principles inbred in him than the manner in which he receives criticism from his co-laborers. One whose interest in his work is personal and is rather in a pride of his way of doing than in the superior excellency of the work done by him, resents criticism as a personal attack. On the other hand, one whose chief interest is in the skillful manner of doing the work, welcomes criticism, because it may help to secure a higher degree of efficiency.—From Dr. Cole's address before the Hodgden Medical Society, of Missouri.

M. Grigoresen, of Bucharest, states that pure glycerine applied to the skin in case of burns acts as an excellent anæsthetic, especially if used early. In severe cases two or three applications should be made, so that the parts are kept constantly wet with glycerine. At first a slight burning feeling is experienced, which soon gives place to local anæsthesia somewhat resembling that produced by carbolic acid. Under this treatment the inflammation is subdued almost completely and only a slight cicatrix is usually left. The glycerine should be lightly rubbed in and the parts then covered with a protective dressing.—*Ex.*

Dr. Oerl has, during the past five years, treated nine similar cases of pleuritic effusion with salicylate of soda, after other remedies, such as phenacetin, pilocarpine, etc., had failed, and with the exception of two instances the results were favorable. In these two the resorption was only partial. The author concludes: 1. Serous pleuritic exudations of long standing may be removed by the administration of the salicylate of soda. 2. The salicylate has in exudative pleuritis, just as in polyarthritis, an apparently specific effect. 3. The fact that, so far as experience with this remedy has gone, no new collection of fluid is observed, makes surgical interference in serous pleuritic exudation not only not imperative, but, indeed, puts operative procedures in the background.—*Medizinal Zeitung*, No. 98, 1891.

Belgium is the first country to make hypnotizing an offence against the law of the land. The law recently approved by the Parliament in Brussels is as follows: "1. Whoever exhibits an individual hypnotized by him or by another shall be punished by imprisonment for from two weeks to six months, and by a fine of $5 to $200. 2. Any person, not a physician, having hypnotized an individual under twenty-one years, or one not in full possession of his mental powers, shall be punished by a fine of $5 to $200, even when the hypnotized individual has not been exhibited publicly. 3. With imprisonment shall be punished, moreover, every person who with the intention of cheating or otherwise injuring, causes a hypnotized individual to sign a paper containing a contract, disposition, obligation, release, or declaration of intention. The same punishment shall be inflicted also upon the person deriving benefit from such a paper."—*Ex.*

The citizens of New York, in 1892, propose to celebrate the discovery of America in their own way, assisted by representatives from every State and Territory in the Union. A great food show is to be held at Madison Square Garden in October of that year. It is proposed at this exposition to show the progress made by this country in the last four hundred years as regards our food supply. The United States is the greatest food-producing country in the world, and as food is the one thing above all others that first claims the attention of the human family, it is safe to predict that the coming exposition will prove one of the most interesting events of the century. It is an exposition that all New Yorkers may well be proud of. This is the only affair of the kind ever held in the world, not even excepting England. Only food products will be allowed on exhibition, exhibitors being restricted to manufacturers or producers, no dealers as such being allowed to participate. Every article of food exhibited must bear the bona fide name and address of manufacturers, all fictitious brands being rigidly excluded. Liquors, specifics, and patent medicines will not be allowed. Every manufacturer exhibiting must guarantee that his goods at the exposition are the same as is offered for sale to the public. The various "Food and Health" shows held throughout this country have no connection with the Food Exposition to be held at Madison Square Garden in October next, this latter being entirely in the hands of the manufacturers and producers.

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CONTENTS

ORIGINAL ARTICLES.
The Use of Morphine and Other Strong Sedatives in Gynæcological Practice. By Hunter Robb, M. D., Baltimore. 617
Opening of the Mastoid Process. By Harry Friedenwald, M. D., Baltimore. . . . 620

SOCIETY REPORTS.
Baltimore Medical Association. Meeting held April 25th, 1892. Aphasia. Hypogastric Neuralgia. 626

EDITORIAL.
Atrophied Faculties. 629
Road Improvement. 630

REVIEWS, BOOKS AND PAMPHLETS. . . . 630

MEDICAL PROGRESS.
The Nerve-Compression Treatment of Hiccough.—Turpentine.—Treatment of Neuritis.—Glandular Abscess in the Crural Canal Simulating Hernia.—Seed Growth and Electric Currents.—The Sanitary Needs of Savannah. . . 631

RECOMMENDATIONS OF THERAPEUTIC AGENTS. . 636

MEDICAL ITEMS. 638

Original Articles.

THE USE OF MORPHINE AND OTHER STRONG SEDATIVES IN GYNÆCOLOGICAL PRACTICE.*

BY HUNTER ROBB, M. D.,
Associate in Gynæcology to the Johns Hopkins Hospital, Baltimore.

The general practitioner and the specialist are directly responsible in many instances for the continuous use of morphine as the means of relieving pain in the treatment of gynæcological cases. The general practitioner frequently meets with cases with ill-defined pelvic pains, cases of intestinal colic or cases with distinct ovarian pains; and these seem, without question, to his mind, to call for morphine. This he administers repeatedly in the acute attacks, oftener by hypodermic injections. The relief thus afforded is, of course, only temporary, and in each subsequent attack the patient will not rest satisfied unless the same treatment is carried out.

Such practice is, I believe, becoming more and more widespread, and it is popular for the reason that it affords the greatest amount of immediate comfort to the patient and to the doctor.

Such methods are not only resorted to by the general practitioner, but by many gynæcologists, who in this way treat ill-defined pelvic troubles associated with pain. Unless, too, we can afford the patient immediate relief, and keep her comfortable and in a happy frame of mind, she frequently will forsake us for those who will prescribe the desired remedy.

Under such circumstances the "morphia habit" is easily contracted, not only in cases where an idiosyncrasy to the drug already exists, but where no such tendency has been present. It is particularly in the cases of acute suffering ac-

*Read at the annual meeting of the Medical and Chirurgical Faculty, held in Baltimore, April 26, 1892.

companied with marked nervous symptoms that the patient readily becomes a morphia habitué. Under this class we place cases of minor pelvic lesions; particularly in those women who have slight disturbances of the normal menstrual flow, producing dysmenorrhœa. If these patients are treated according to their symptoms alone, they will seem to demand immediate relief at all hazards. The nervous symptoms predominating in these cases as a rule, ordinary measures adopted are unsuccessful, except by agency of morphine or some efficient substitute. These cases, in a short time, become thoroughly dependent upon the drug and are rarely entirely relieved or comfortable unless under its influence. Also where displacements of the uterus exist, where the most prominent and constant symptom is backache, nothing affords such instantaneous relief as morphine. Such cases soon become completely addicted to its use. The ultimate outlook under such treatment is practically hopeless. The nervous, worn-out woman, suffering pain at her menstrual period, sufficient to completely overthrow her nervous command, naturally seeks the sedative to rid her of her discomfort, and certainly cannot be censured for so doing. If morphine is administered under these circumstances, its seductive effects soon form the sheet-anchor of her existence, and in her nervous condition the habit takes possession of her very soul.

Analysis of cases.—The practice of using morphia, then, for simple pains and neuralgias of different varieties, cannot be too strongly condemned. In many instances the patient applies directly to the drug shop for morphine or for some preparation containing it or some of its constituents. The druggist, too often irresponsible, thus dispenses these drugs to whomsoever may desire it, and as he is in utter ignorance as to the necessity for the drug, neither can he nor the patient appreciate the dangers which are incurred. As these preparations afford the most relief, without further thought they take it for granted that it is precisely what their condition requires, and they then resort to its use on the slightest provocation, without ever asking a physician's advice. Such patients, long before they are aware of it, learn to depend entirely upon it for relief and in this way quite unconsciously fall under its pernicious influence: so that in a brief time they require the drug independently of the primary condition for which they began its use. The physician who is called to attend this class of patients is driven to his wit's end to know what to prescribe, and unfortunately he resorts too quickly, in the vast majority of cases, to this dangerous method of treatment. If a patient becomes a victim of the habit in this manner, the attendant should be held personally responsible, and the legal restriction provided should be enforced to prevent the drug from being sold by any druggist, without a physician's prescription.

The administration of morphine after operation is also too much of a routine treatment with *surgeons*. To this practice the *habit* can unquestionably be traced in many patients. It is the practice of these operators to keep their patients under the influence of morphine for two or three days subsequent to operations. Unless physicians are extremely careful they easily fall into the way of prescribing morphine under these conditions, and the patient will be in great danger of becoming addicted to its use. It is occasionally called for, but in the vast majority of cases I feel sure that patients do not require any sedative at all after operations. We should, to this end, enlist the moral support of the patient herself, explaining that if she endures the suffering for a short time, she will make a much better recovery. The effect of using morphine after operations is not only that after a short time the patient feels the necessity of its repeated use, but she is much more difficult to manage, becoming restless and fretful, com-

plaining loudly of the simplest suffering, and altogether her mental condition is unbalanced.

In the care that I have had of over 700 cœliotomies, (abdominal sections) and a large number of plastic cases, morphine has been required in but few instances. Where it was impossible to do without it, at the outside but one or two doses have been given; it can thus, perhaps, in a small percentage of cases, be safely administered; but I have observed that when only one hypodermic, even of ½ of a grain, has been given, in some instances the patient would be thoroughly demoralized for two or three days; as previously stated, it not infrequently takes as long as this for its depressing effects to entirely disappear.

I have met with cases that have acquired the morphia habit after gynæcological operation, coming from the clinics of eminent gynæcologists. In some instances they not only acquired the morphia habit, but also, what so frequently happens, they were obliged to resort to stimulants, when they were not under the influence of morphine. I have seen such a condition utterly destroy a patient's life. Many such cases undoubtedly exist to-day, solely as a consequence of what I believe to be the careless and unnecessary administration of morphine after operations. It is the iron-bound rule in the gynæcological department of the Johns Hopkins Hospital, in post-operative cases, to give it only in case of dire necessity. Long series of serious cœliotomies and plastic cases there convalesce thoroughly, satisfactorily and comfortably, without the administration of any morphine or other sedative.

In what cases is it permissible to use morphine?

A proper but limited use of morphine is justifiable in cases of inflammatory pelvic disease. Further, in cases impossible of relief by operative measures, as cancer of the uterus involving the broad ligaments or neighboring viscera. In order to relieve the great suffering that is present at times, it is necessary to use morphine, but even in these instances it should be relied upon only as a last expedient, as many cases are rendered comfortable and practically free from pain by the use of local treatment; such as cleansing the parts by hot, medicated douches, the use of the cautery or curette, singly or in combination. Also in cases of large adherent myomas where the structures are so universally bound down that we have nothing else but palliative measures to depend upon.

Finally, in cases of pelvic inflammatory disease preparatory to operative measures: In the treatment of these cases it is, however, of the greatest importance to examine the patient complaining of obscure pelvic lesions, under anæsthesia; this is the only absolute means of ascertaining the condition of the pelvic contents. Too much importance, I feel sure, cannot be laid upon this as a routine practice. We are thus at once in a position to carry out our treatment, having ascertained the local condition of the parts by a careful process of exclusion. For instance, if we have a patient complaining of indefinite pelvic pains who also presents a history that would seem to indicate, positively, inflammatory disease, without, however, the examination under anæsthesia, we are not able to say positively what is the condition of the pelvic contents. Therefore, if in a given case we find marked structural changes or adherent masses with a suggestive clinical history, we can safely, perhaps, resort to small quantities of morphine preparatory only to near operative measures. This practice, however, should be a guarded one, and we must use only sufficient of the sedative to act merely as a temporary agent, or, in other words, until the operation can be performed. Only under these circumstances do I believe it is ever judicious to employ morphine for pelvic inflammatory conditions.

Many cases of established morphine habit I have seen successfully cured by operative measures. This method of treatment originated with Dr. Kelly, who carried it out successfully in numerous instances in patients who, as a rule, had passed through the hands of several gynæcologists who operated for various symptomatic abdominal inflammatory diseases. These patients were prepared for cœliotomy and carefully examined, bimanually, for adhesions. The abdomen was opened, and a search made and any adhesions released; then the abdomen was closed and morphine in any form was absolutely forbidden. I believe this to be a method worthy of trial in these gynæcological morphia cases that are otherwise hopeless.

In conclusion I make the following suggestions :—

1. That general practitioners, but more particularly specialists, should carefully scrutinize every prescription they write containing morphine, and that under no circumstances should its renewal be allowed unless under their personal supervision.

2. The patient hould never be allowed the use of a hypodermic syringe.

3. The druggist should be prevented from dispensing morphine without a prescription.

4. When morphine is prescribed, the patient should never be informed of the character of the drug.

These remarks apply to all analgesics, and sleep producers, particularly chloral, chlorodyne, sulphonal, etc.

As substitutes for morphine, I would advise, where practicable, electricity; internally, in guarded doses, gelsemium, phenacetin; and as local applications, the cautery, oil of peppermint and oil of winter green.

OPENING OF THE MASTOID PROCESS.

BY HARRY FRIEDENWALD, M. D.,

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It is not the purpose of this paper to add anything new to the indications for, or to the methods of opening the mastoid process. Nor will it contain a resumé of the enormous literature upon this subject. In as simple a manner as I am able, I wish to present the results of my experience and to add as much as I can to the proper reception of this operation by the profession. I shall endeavor to show that the dangers of the operation have been much exaggerated in the minds of both the profession and the layman, and that for this reason it has often been avoided entirely or postponed until it was too late to save the life of the patient.

The danger of suppurative inflammation of the middle ear and its neighboring bone cavities is recognized more and more every day. In many cases of death from suppurative meningitis or cerebral abscess or septic thrombosis of the sinuses we are no longer satisfied to regard these causes as "idiopathic," but we look for and often find suppuration and caries of the cavities forming the middle ear as the primary lesion.

One of England's greatest surgeons, MacEwen, at a meeting of the British Medical Association a few years ago, said that "A person who had a chronic discharge from the ear was in the position of one who had a charge of dynamite in the interior of his head which might explode at any moment." This suffices to teach us the necessity of doing all in our power to make these conditions harmless.

One of the most important means is the early opening of the mastoid process when the indications, as accepted by most aural surgeons, are present.

Concerning the mortality of the operation in itself, *i. e.*, irrespective of that

due to serious complications present at the time of operating—let me quote Politzer†: After stating numerically the result of the operation in his own experience and also in that of other great operators, he concludes that "the operation in itself, excepting in a few anatomically abnormal cases, is not dangerous, if the operator possesses that degree of practice and skill necessary for an operation near the brain and great venous sinuses." He also says that improved technique and careful antisepsis will still further decrease the mortality, and he quotes Schwartze, whose early statistics showed a mortality of 20 per cent. and whose latest but 6 per cent., and Lucae, who did not lose a single case in one hundred through the operation. In his own series of 65 cases, but two were fatal; one of these had total necrosis of the petrous bone with abscess of the cerebellum, and the other had phlebitis of the sinus, and erysipelas before the operation.

The indications, according to Schwartze, for opening the mastoid process, are:

1. Acute inflammation of the mastoid process with retention of pus in the cells if the symptoms do not permanently subside after a Wilde's incision. We are not to wait until symptoms of cerebral irritation and pyæmia appear.

2. Recurrent swelling over the mastoid, which either disappears or forms an abscess with or without fistulous opening through the skin. Symptoms of danger to life need not be present.

3. If on opening an abscess in the neighborhood, a fistulous canal is formed leading into the bone.

To these Gruber adds:

4. If in the course of inflammatory processes in the ear, there is pain which does not yield to other measures, the operation is indicated even when no inflammatory signs are visible in the mastoid.

5. In otorrhœa of long standing which is not to be explained by the objective examinations of the Eustachian tube and middle ear, which resists the usual remedies, and in which there is offensive secretion containing cholesteatomatous masses or pieces of bone, the mastoid process should be opened even when there are no evident changes in it. Various operators differ as to the time to operate. Schwartze advises an early operation; some believe in trying other measures for a long time or until serious symptoms arise, in the hope that a favorable change many make the operation unnecessary. I am convinced that general surgical principles favor early operative interference. At the same time, in view of the fact that many cases of acute mastoiditis get well rapidly under antiphlogistic treatment, this means should always be tried for a short while before operating (Schwartze limits the time to about 8 days.)

There are various methods of operating. The trephine, which was used formerly, has been almost entirely abandoned, and the bone is opened with chisels and sometimes with bone forceps, or when soft, with the sharp spoon. In order to avoid injury to the lateral sinus or the dura mater it is advisable to enter very near to the auditory canal and not higher than the upper wall of the latter. As it is our object to reach the antrum or space joining the drum cavity with the mastoid cells—a cavity lying above and exteriorly to the former—the direction of the further course should be that of the auditory canal. It is not proper to enter the chisel deeper than 1.5 cm. for fear of injuring the facial nerve or the semi-circular canal.

If the mastoid abscess has found a way through the bone it is proper to follow the course of the fistula.

Gruening‡ has recently recommended the removal of the entire outer wall of

†Lehrb. d. Ohrenheilk., p. 403.

‡New York Med. Jour., January, 1892.

the mastoid process, by which means he claims to be able to locate the position of the lateral sinus and thus rid the operation of one of its chief dangers.

I should also like to mention that several surgeons have advised the removal of the posterior wall of the auditory canal and thus reach the antrum of the mastoid, but aural surgeons have accepted this method only in rare cases.

Case 1.—Mr. R., of Maryland, came to my office July 23rd, 1891. He had had grippe during the preceding April, which was complicated with suppurative inflammation of the right ear. At first there was much pain. The otorrhœa lasted until about two weeks ago, when his neck became stiff and a swelling appeared behind the ear.

On examination, a large fluctuating swelling was found over mastoid process pushing the auricle forward in the characteristic manner. The posterior wall of the auditory canal was pressed so far forward that examination of the deeper parts of the canal was impossible, a sign of great importance, according to Schwartze, as an indication for operating. There was no fever. The gentleman was admitted for the operation as a private patient into the city hospital. Operation April 24th. After shaving the neighborhood of the mastoid and thoroughly disinfecting it, and anæsthetizing with chloroform, a long incision was made, about 1 cm. behind the line of junction of the auricle, and parallel with it, through the swollen tissues down to the bone. Thick pus of pale greenish color flowed out of the incision. After cleaning out the wound and exposing the surfaces by pushing the periosteum out of the way with a rasparatory, an exceedingly small opening was found near the anterior edge and below the middle of the process. This was carefully enlarged by chisels until about 1 cm. in diameter, and a cavity as large as a small hazel-nut was found filled with pus and granulation tissue.

The cavity was scraped perfectly clean with sharp spoons, irrigated and packed with iodoform gauze. The incision was partly closed in its upper portion and the wound dressed in iodoform and iodoform gauze. It remained perfectly aseptic and was dressed every fourth day and kept packed with iodoform gauze to prevent too early union of the surfaces.

On August the 1st—that is, one week after the operation—the patient was allowed to leave the hospital and come to the office for dressing. The wound healed rapidly and the canal into which it was converted disappeared entirely in about 7 or 8 weeks after the operation. Let me add, in closing this case, that the patient felt better soon after the operation and had no further pain. The ear also began to improve soon and hearing was in great part regained. There was no discharge from the ear.

Case 2.—Mr. P., of North Carolina, a student of medicine, first consulted me February 23, 1891, on account of acute suppurative otitis media of the right ear of two days' standing, following grippe. There was considerable pain in the ear and also sensitiveness over the mastoid process, with slight swelling but no redness of its surface. The auditory canal contained a bloody discharge. The posterior segment of the drum-head was much swollen and very sensitive. I made a small incision here which gave great pain. He was then treated with the 10 per cent. solution of carbolic acid in glycerine as advised by Hewetson and Hartmann. He returned in two days with profuse yellow discharge and diminished pain. The patient was now looking very badly, but continued his studies with great energy.

He did not present himself after this for four weeks. On March 24, when I saw him, there was profuse suppuration. He was then advised to use daily in-

jections of boiled water and (after drying canal) insufflations of boracic acid. The seriousness of his trouble was explained to him and he was asked to call every other day. I saw him on March 27, when the condition was about the same, and again on April 3. Let me remark, parenthetically, that the patient was now in the midst of his final examinations, but that it became impossible for him to continue. He had had excruciating pain during the last week and sensitiveness behind the auricle; on April 1, a large swelling had made its appearance over the mastoid, and then the pain diminished somewhat. The auricle was pushed forward and outward, as in case 1, by the large fluctuating swelling. There was no fever, but the patient had become very emaciated and was in a very bad condition.

Operation, April 4, 1892, at the City Hospital. The patient was carefully prepared and anæsthetized with chloroform. A long, deep incision was made (as in case No. 1) and this exposed a deep abscess and allowed the thick yellowish pus to flow out. With a probe, an opening was found on the surface of the mastoid about ¾ mm. in diameter and beneath this a large cavity. The periosteum was removed, the opening carefully enlarged so as to admit the little finger, and it was then evident that the outer layer of the mastoid was but a thin shell of bone and it was removed in great part. The opposite or inner wall of the cavity was very soft and when examined with the blunt probe—an instrument which should be used constantly in these operations—*no bone could be felt,* so that it was very probable that the soft granulations were upon the surface of the exposed dura mater. Some of the superficial granulations were removed very gently. The cavity was irrigated with sublimate solution and was carefully filled with iodoform gauze. The irrigating fluid did not pass out through the ear, which was still suppurating. The wound was dressed with iodoform and iodoform gauze, after having been closed with a suture in its uppermost portion.

The patient did not stand the chloroform well, but vomited and felt very sick even on the following day. The ear felt much better. There was no fever.

On the fourth day the ear was dressed and the wound irrigated. There was still no communication with the middle ear and no suppuration from the ear.

On April 9th (*i. e.,* five days after the operation) the patient had improved so much that he was able to take special examinations in those branches which he had been forced to drop.

The wound grew rapidly smaller and he finished his examinations successfully. On the 23rd (19 days after the operation) he left for his home in North Carolina, where, according to a letter received shortly after, he was progressing nicely.

I wish to draw attention to the fact that though there was not sufficient communication between the middle ear and the wound to allow the irrigating fluid to pass through, still the discharge from the middle ear ceased immediately after the operation. This curious fact is not uncommon, and is discussed by Politzer. The seriousness of this case need not be dwelt upon when we remember that the dura mater was exposed and covered with granulations. The operation was performed three days after the swelling appeared but I should have advised it earlier if I had seen the patient.

Case 3.—Was a colored girl about 20 years old. She was suffering with suppurative otitis media of long standing. For some time I advised her in vain to submit to an operation, for the pain in the ear and mastoid process was very great, though there was not much swelling; her condition appeared to me to be very serious. The pain finally became so great that she came and begged to have the operation performed. The otorrhœa had stopped for several weeks. I had seen her only at long intervals.

On November 7, 1891, I had her admitted to the City Hospital and on the same day performed the following operation. The patient was treated as were cases 1 and 2, and anæsthetized with chloroform. The incision opened a deep abscess over the mastoid. On examination, the surface of the bone seemed at first quite normal, but a careful search revealed a small opening about 2 mm. in diameter in the anterior upper part of the process. Let me say here that these fistulous openings are often very small and difficult to find, as in this and in the first case, so that failure to find one in similar cases does not always denote that there are no openings and that the interior of the process is normal.

In this case the opening was enlarged and an irregular abscess cavity in the bone was exposed as large as a small hazel-nut. This was carefully cleaned of pus and granulation tissue by the use of the sharp spoon, disinfected and packed with iodoform gauze. The long wound was closed somewhat from above by two sutures and an iodoform dressing applied. There was no pain whatever after the operation and no rise of temperature. Six days afterward I redressed the wound for the first time but found it as clean as when first dressed. The patient being relieved of pain, soon left the hospital against my wish, and when I saw her soon afterward there was a small fistulous canal remaining. This I am sure would have been prevented if the patient would have submitted to regular treatment.

The danger of long delay is well shown in the following case in which it cost the patient's life.

Case 4.—J. B., aged 60 years, was admitted, Aug. 22nd, 1891, into the City Hospital. He had had an intermittent otorrhœa from the right ear for about seven months, but this had ceased about six weeks before. At this time the pain became more intense, and about three weeks later it forced him to leave his work. I did not see the patient till Aug. 22nd, 1891. When examined by me the patient was suffering much pain. There was a large painful swelling behind and above the ear, which had made its appearance ten days before. Fluctuation could be felt indistinctly. The swelling was farther from the ear and higher than in the other cases and did not push the auricle out of position. The external auditory canal was clean, the deeper parts were red and swollen. The watch was heard on contact. On inquiry I learned that he had had a severe chill three days before.

Operation, Aug. 22nd, 1891. Same preparations were made as in other cases. Chloroform anæsthesia. Long incision through part of greatest swelling, and allowed considerable amount of pus to escape. Found an opening about 5mm. in diameter, filled with granulations. This was enlarged until it admitted the little finger (10-12mm). Cleaned out gently. The opening is situated about 3 cm. from auditory canal and it was no surprise to find that the inner plate of the bone had been destroyed. The cavity was then washed out thoroughly and treated like other cases. Patient recovered nicely from the anæsthesia. During the following night there was a severe chill.

Aug. 23. Patient became very weak after the chill; temperature between 103° and 104°.

Aug. 24. Patient sank into low muttering delirium and died that afternoon.

The post-mortem examination was made by Prof. N. G. Keirle, who found: (1) Diffuse meningitis, especially over the convex surface of the cerebrum; (2) Small open abscess cavity on the under surface of the temporal lobe where this touches the margin of the cerebellum and opposite to the opening in the bone; (3) Firm white fibrin thrombus in lateral sinus which is completely eroded at the opening in the bone; (4) Large opening on inner surface of temporal bone, to-

gether with a second abscess in the central part of mastoid. (Specimen.) The middle ear and drumhead appear but little altered.

In this case the patient was brought to me after pyæmia had set in. The physician who had attended the patient had advised an operation long before, but his advice was rejected by the patient. It was only when he found that he was getting weaker, and when the pain grew intolerable that he finally consented to have it done, and he was then brought to me. It was then too late. Some authorities regarding the hopelessness of this condition look upon it as a contra-indication to the performance of the operation. I cannot accept this view, especially not since Moos published a case in which there were all signs of pyæmia from thrombosis of a sinus with frequent chills which gradually recovered after an operation.

Case 5 is one of no ordinary interest. The patient, T. C., was a boy aged 17, of very delicate build. Since childhood he had otorrhœa of the right ear—for a long time he had had a number of fistulæ in front and behind the ear. He had been under treatment, but was getting no better. The auditory canal was partially filled with very firm polypi, some of which were removed. Diagnosis: Necrosis of temporal bone.

Operation, Aug. 20th, 1890. Chloroform anæsthesia. Our intention was to open over the mastoid and get free drainage from this point, after separating any necrotic portions. An incision was made behind the auricle about ½cm. from line of junction. This was followed by great hæmorrhage. Necrotic bone was felt to cover a large area above and below. The wound was rapidly extended upward and forward over the auricle to meet the fistulæ in front, at the same time plugging the lower portion of the wound firmly with absorbent cotton to control the hæmorrhage. The bleeding could be controlled with utmost difficulty. It was quite out of the question to attempt to use artery forceps, for the whole surface of the wound was bleeding. It could not be inspected for a moment. By the finger, the whole upper part of the temporal bone was likewise found to be ulcerated, with rough and ragged edges. The excessive hæmorrhage forced us after a time to desist from any further attempt to clean the bone; the wound was firmly tamponed with absorbent cotton which had been soaked in a sublimate solution. The patient lost a great quantity of blood and was very weak after the operation. He was put in a warm bed and rapidly recovered, though I had grave fears after the operation that he would not survive the hæmorrhage.

I learnt afterwards that the patient's father was a "great bleeder" and that he had shown evidence of hæmophilia. The ear was dressed four days after the operation and water passed freely through the wound when injected into the auditory canal. The wound was dressed daily and showed a tendency to close rapidly, but several fistulæ remained. The patient was afterwards treated, until recently, with antiseptic injections to keep the wound clean. He left the city recently.

I believe that had we not had to deal with this unexpected hæmophilia the bone could have been thoroughly freed of all necrotic portions or sequesters and perfect recovery brought about.

Operations on the mastoid are not only made when it contains an abscess cavity or sequesters. Among the other conditions which such operations can relieve are those classed under "sclerosis of the mastoid process" or "condensing mastoiditis." Such a case is the following:

Case 6.—H. M., male, aged 52, was admitted into the City Hospital early in August, 1890. He complained that he had had ear trouble since childhood. During last month he had had very severe pain in right eye, which could not be re-

lieved. There was some discharge. The drumhead was covered with pus; hearing moderate. The pain seemed to be centered in the mastoid process and this was exceedingly tender to the touch though there was neither redness nor swelling of this region. Our ordinary means failed to relieve the pain. After being under treatment for one week I decided to open the mastoid process.

Operation, Aug. 14th, 1890, performed in a manner similar to that described in cases above. The surface of the mastoid appeared normal. We entered with the chisel, just behind the auditory canal. We had not gone very far before it was evident that it was a case of "sclerosis" in which the spongy bone of the mastoid is replaced by solid bone as hard as ivory. We entered almost half an inch before we reached a small air cell. Opening in the bone was funnel-shaped. It was cleaned and irrigated, and then the skin wound was closed entirely and dressed with iodoform gauze.

The wound healed by first intention. As is the rule, so in this case, the pain subsided entirely immediately after the operation and did not reappear. There was likewise no further suppuration from the middle ear.

I performed the operation in three other cases; one has been published† as "a case of extensive caries and cholesteatoma, etc.," the other two were in the nature of exploratory operations. I wish only to say now in reference to those cases, which I shall publish at some future time, that both recovered rapidly from the operation.

In conclusion, let me express the belief that the day is not far distant when the operation under consideration will be much more frequently practised. Authorities in otology are already almost unanimous in recommending its wide and frequent application. I am convinced that it will often be performed simply as an explorative measure, especially in the treatment of otorrhœa complicated with necrosis, with cholesteatoma or with severe pain.

Let me warn against the reliance upon the so-called conservative treatment with the internal exhibition or the external applications of various remedies. This is a disease which must be treated surgically. I am of the opinion, based upon the experience of the cases I have narrated, that a simple incision down to the bone—known as Wilde's incision—cannot be an efficient means of treating internal mastoid affections. I called your attention to the fact that in all of my cases in which there was an abscess over the mastoid, a primary abscess cavity was found within the mastoid, and in several the fistulous canal was so narrow that it could scarcely be found. A simple incision might relieve this condition but it is very likely not to. It will not relieve us of the danger of extension of the mastoid affection and it will almost inevitably leave a fistulous opening.

I hope I have made clear that mastoid affections are to be treated rationally and surgically—that we are not to lose valuable time in treating abscesses and other dangerous conditions by poultices and salves and internal medication, but that we must learn to enter safely into the process and remove the dangerous or painful source of disturbance.

Society Reports.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD APRIL 25TH, 1892.

The Association was called to order at 9 P. M., the President, Dr. Blake, in the chair. Reading of minutes dispensed with.

Dr. Pennington, of Committee of Honor, reported favorably on the names of

†Archives of Otology, Vol. XX, p. 1.

Dr. E. W. Eilau, 1523 E. Baltimore St.; and Dr. J. C. Schofield, Orangeville, Md. (Both proposed by Dr. Biedler). Both elected. No other reports. Dr. Blake proposed for membership Dr. Stephen Crowe, 1011 Linden Ave.

Dr. J. T. King read a paper on APHASIA. (Will appear later in the JOURNAL.)

Dr. J. I. Pennington reported case of young man—aphasic. Got up as usual in the morning but found at the table that he could not speak, neither could he write. *Yes* seemed to be the only word left. Some improvement followed, but cerebral softening soon came on, from which he died. History of repeated attacks of rheumatism and consequent valvular disease of heart. Dr. Pennington cited another case of aphasia following puerperal convulsions—patient used left side by preference. Dr. Pennington suggested a clot in Dr. King's case. Dr. Blake agreed with Dr. Pennington about clot in Dr. King's case—a hæmorrhage, very small. Dr. Gibbons has now under treatment a lady aged 65 years, paralyzed eight months ago; difficulty in testing the case on account of deafness. *Yes* seems to be the only word left; counts one, two, three; repeats a certain peculiar expression; mind improving as well as speech; unconscious at first; treatment, iodide of potash.

Dr. E. G. Waters reported cases of HYPOGASTRIC NEURALGIA as follows:

CASE I. That of a man, very tall, fine physique, never sick before. Taken with violent pain in the upper part of the iliac region. Treatment, purgatives. opiates, etc. Dr. Waters thinks the ureter principally involved.

CASE II. That of young man, taken ill with violent pain in the upper iliac region, while returning from business; treatment similar to that of above case, with external applications.

CASE III. That of a lady, pain commencing in bladder (as she said), extending up ureter toward the kidney, obstinate vomiting; injection (rectal) afforded relief.

CASE IV. One of Dr. Ingle's, a lady confined shortly before; after getting up she imprudently went to market. Dr. Waters gave bromide, finally yielding to morphia.

CASE V. Similar to Dr. Ingle's, a lady recently confined; bromide and tr. opii deod. gave relief. In these cases the patient has tendency to burrow fist in the iliac region.

CASE VI. A girl with pain on left side, history of malaria, anæmic, treatment similar to that already mentioned. Bore bromide badly.

CASE VII. A young lady from Philadelphia; trouble seemed to be located in ovary; came on soon after her menstrual period; had been treated in Philadelphia, for perityphlitis.

CASE VIII. A lady upon stepping out of a car; pain seized her in left side; on reaching home it was in right side. Bromide and bichloride afforded relief but it soon returned and permanent relief was afforded by rectal tube.

CASE IX. An English lady troubled similarly but obtained no relief from treatment above indicated. Epispastics applied to the back eased the patient.

Dr. Reid asked if the use of the tube was to empty the intestine or for the effect of the hot water.

Dr. Waters replied "both." Dr. Reid formerly used the tube but now he employs a pill of opium and blue mass.

Dr. Pennington said there was one cause omitted by Dr. Waters, viz.: passage of gravel from kidney to bladder.

Dr. R. H. Ellis asked what Dr. Waters attached to the end of tube.

Dr. Waters answered: Davidson's syringe.

Dr. Ellis said that if the bowels were filled with fæcal matter it would be impossible to pass the tube up any distance. Agreed with Dr. Pennington about passage of gravel and emphasized the use of morphia, especially hypodermically.

Dr. Reid asked Dr. Ellis if opium given by stomach might not have a local effect and thus have a better effect than morphia.

Dr. Ellis answered, No. Morphia acts through the nervous system after having been absorbed. The local effect of opium goes for nothing.

Dr. Pennington said that when given by mouth morphia often fails to act, give it hypodermically.

Dr. Blake suggested that the rectal tube instead of passing up 24 inches might fold upon itself and then the nozzle of Davidson's syringe would answer as well. Dr. Waters is more fortunate in getting the pain-relieving effect of bromide of potash than Dr. Blake.

Advised use of hypodermic syringe, but use it discriminately.

Dr. Reid: In these cases two objects are to be accomplished: give relief and remove cause. Hypodermic syringe affords relief but does not remove cause. The combination of opium and blue mass is very seldom vomited. As to whether opium and morphia should be used, it is simply a question of experience.

Dr. Ingle said that doubling up of rectal tube may occur, but we can generally know when this occurs; by injecting water as soon as tube is introduced, all difficulty is obviated.

Dr. Waters, in conclusion: Dr. Ingle's experience coincided with his own by changing position of patient; tube may be disengaged and made to pass up. The hypodermic syringe is not altogether safe. Does not rely upon bromide exclusively as anodyne, but as an astringent upon capillary vessels; and in conjunction with other remedies. Object of reporting these cases was to point to obstruction. In no case has he supposed the passage of calculus along the ureter. Opium is not the only remedy for pain.

Dr. Muse proposed for membership Dr. Thomas A. Milliman, corner Arlington and Hopkins Avenues.

Dr. Waters read report of Committee on Physicians' Mutual and Beneficial Society. On motion of Dr. Keene, report adopted. Dr. Pennington moved (Dr. Jones seconded) that the vote be reconsidered and brought up at the next meeting, at which the whole evening is to be taken up by discussion of this subject. Remarks by Drs. Keene, Gibbons, Jones, Reid. Carried. Dr. Waters moved that it be continued in the hands of the Committee. Carried. Adjourned.

EUGENE L. CRUTCHFIELD, M. D., Sec'y Pro. Tem.

EMETIC IN OPIUM POISONING.

D. T. Smith recommends common salt and mustard. He says: "A couple of heaping teaspoonfuls of each of these in as many goblets of warm water is one of the safest, quickest, and most efficient means for promoting vomiting. Do not wait to mix them; if they are not both at hand, give the salt and then the mustard after it can be fetched. A half-ounce or so of alum in water will prove a useful adjuvant, retarding further absorption by the stomach, but of itself rather slow and uncertain."—*Bulletin of Pharmacy.*

The Board of Trustees of Jefferson Medical College, at their meeting April 7, 1892, instituted a Chair of Clinical Gynæcology with a seat in the Faculty, and elected Dr. E. E. Montgomery to the new Chair. Dr. Montgomery has been Professor of Gynæcology in the Medico-Chirurgical College.

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BALTIMORE, MAY 14, 1892.

Editorial.

ATROPHIED FACULTIES.

It is said of a famous scientist that his thoughts were so exclusively devoted to his specialty that certain forms of mental activity which were quite well developed in youth had disappeared by the time he reached mature age. Music, which had once been pleasant to him, now gave him positive discomfort.

The question comes up early in the physician's career "Must I not, in order to succeed in my profession, give up everything and devote my whole time and thought to medical matters alone?" Certain practitioners give a very positive affirmative answer. They say that a physician should be known to the public simply as a physician and nothing more. That open participation in non-medical enterprises of any sort lessens the esteem of the public for the practitioner. We are happy to say, however, that other physicians of great experience flatly deny the truth of these statements, and instance individuals of great eminence in the profession who are known in the community as men of wide culture and of great attainments in general literature, history, art, etc., and claim that this diversity of mental activities and breadth of sympathy is one of the secrets of their medical eminence.

It must be admitted that at present in America the tendency is rather toward discouragement of side interests. In any country and at any time medicine has always claimed the first place in the thoughts and labors of him who would be a first class physician. Just now her demands for the fealty of the young American practitioner are especially clamorous. He must attain the professional learning and experience, formerly supposed to be the characteristic of mature old age, while he is in his twenties. He must not only take in and assimilate by this time the details of the principles and practice of medicine and surgery, including the specialties, but must also have a fair knowledge of the intricate methods and extensive literature pertaining to bacteriology. He must keep up, too, with the rapid progress of the therapeutic invention and experimentation.

It is comforting to note, however, that these enormous labors are absolutely required only of those who seek fame and high position on the scientific side of medicine and surgery. The old fogy whose aim in medicine is simply to get his patients well and to earn a modest income may, if he conducts his life on sensible principles, find spare hours or half-hours now and then sufficient for the culture of art, music, botany, etc., or the attainment of a fair knowledge of some department of history or general literature. Such pursuits will broaden his sympathies with his fellow-men: will give him intelligence in conversation; will be a safeguard against despondency; will hinder that atrophy of character seen in men who have either stifled or satiated the aspirations and ambitions of early life and are making self-love and money-heaping the sole object of existence.

ROAD IMPROVEMENT.

There is no subject that more directly interests the country doctor than the proper construction of road-beds. His day's work is sufficiently arduous, even without the continual jarring of his nerve centres which results from riding over ill-built and worse kept country roads; to say nothing of the wear and tear upon horse and buggy caused by mile after mile of rocks and mud holes.

It is cheering, therefore, to observe the interest with which certain of our great literary monthlies are taking up the subject of the "art of road-making." The prevailing opinion seems to be that the State should take control of the construction of roads within its boundaries, borrowing the necessary money, and furnishing competent engineers to oversee the work. Certainly the skilled engineer ought to be able to make a better, cheaper and more lasting road-bed than the untrained farm-hands who usually take turns at the job.

Part of the increase of interest in the subject is evidently due to the development of bicycling.

Whether our State ever furnishes funds for general road-building or not, it is to be hoped that our Legislature will soon provide for their construction under the superintendence of a corps of competent engineers, located at convenient points throughout the State, and supported at public expense.

Reviews, Books and Pamphlets.

Psycho-Therapeutics, or Treatment by Hypnotism and Suggestion. By C. Lloyd Tuckey, M. D., etc. Third edition, revised and enlarged. London: Bailliére, Tindall & Cox, 20-21 King William St., 1891. Cloth, 8vo, 320 pages. Price $2.00.

The rapid exhaustion of the first and second editions of this book within two years after its appearance bears witness to its value. The author is a follower of Dr. Liebeault, of Nancy, whose method he describes in full, adding the record of many clinical cases treated successfully by the author and by other workers. Brief references to the methods of other schools and workers of the present and the past are given. The book is attractive, readable and instructive.

Diseases of the Urinary Apparatus, Phlegmasic Affections. By JOHN W. S. GOULY, M. D., Surgeon to Bellevue Hospital, New York. D. Appleton & Co. Cloth, 8vo, pages 333.

In this neat volume the reader will find the subject of urinary disease in the male very carefully treated in thirteen chapters. The work is both well arranged and very exact. It is based on lectures delivered before the class in 1891. We take pleasure in bringing it to the notice of physicians.

The Pocket Pharmacy with Therapeutic Index. A résumé of the clinical applications of remedies adapted to the pocket-case, for the treatment of emergencies and acute diseases. By JOHN AULDE, M. D., New York. D. Appleton & Co., 1892.

In this volume the author takes 24 drugs and combinations of drugs, which are prepared in tablet form by the drug firm of John Wyeth & Bro., and indicates their alleged therapeutic use.

Practical Midwifery. A Hand-book of Treatment. By EDWARD REYNOLDS, M. D., Assistant in Obstetrics in Harvard University; Physician to the Out-Patients of the Boston Lying-in Hospital, etc. With 121 illustrations, cloth, 400 pages, 8vo, New York. Wm. Wood & Co. 1892.

In this handy volume the author seems to us to have succeeded in his efforts, namely, to furnish a brief practical guide for the physician in the lying-in chamber. An attempt to avoid confusion has been made by giving but one method of treatment for each complaint. We do not seek to detract from the general value of the book when we state that, with reference to Hegar's sign of pregnancy, the author has followed the well-known error of Drs. Grandin and McKee. The sign which Hegar discovered (*the compressibility of the middle segment*) is described, with translations from the original papers, by Dr. A. K. Bond, in the MARYLAND MEDICAL JOURNAL, May 19th, 1888.

A Treatise on Bright's Disease of the Kidneys: Its Pathology, Diagnosis and Treatment; With chapters on the anatomy of the kidney, albuminuria and the urinary secretion. By HENRY B. MILLARD, M. A., M. D., Fellow of the Academy of Medicine, of New York (and of many other home and foreign societies enumerated.) With numerous original illustrations. Third edition, revised and enlarged, 314 pp., 8vo. Price $3.00. New York: Wm. Wood & Co. 1892.

The volume is the result of many years' experience in hospital, private practice and pathological laboratory. The first part of the volume is devoted to the minute anatomy of the kidney and the various microscopic and chemical methods of urine examination. The rest is devoted to the discussion of nephritis and its treatment. Nephritis is considered under the heading of "croupous nephritis, acute and chronic;" "suppurative nephritis," "interstitial nephritis, acute and chronic;" and "nephritis without albuminuria;" a chapter on which subject is inserted into the discussion on chronic interstitial nephritis. The *treatment* is given separately, in chapters on "the treatment of acute nephritis," "of chronic croupous nephritis;" "of suppurative nephritis." The work is very handsomely gotten up and is a valuable and interesting addition to the physician's library.

Medical Progress.

THE NERVE-COMPRESSION TREATMENT OF HICCOUGH.

Every practitioner has met with cases of hiccough which seem to resist all known methods of treatment. As the continually recurring spasmodic contraction of the diaphragm is not only highly distressing to the sufferer, but may,

through the exhaustion it produces, be the immediate cause of death, it is a matter of importance to be acquainted with a ready, speedy, and sure method of controlling this symptom. In many instances it is probably due to the presence of unabsorbable fluid in the stomach, and the rational remedy is an emetic, preference being given to apomorphine administered hypodermically. When, however, hiccough occurs as a neurosis, an infallible remedy is found in digital compression of the phrenic nerve, if we may believe M. Leloir (Acad. des Sciences, 18th ult.). This is not at all a new idea, for it is mentioned by several English authors. But the somewhat extensive experience of the method possessed by M. Leloir is worth recording. That gentleman tells us that five years ago a girl of twelve was brought to him in order to be treated for incoercible hiccough which, recurring every half minute, had lasted for one year, and had, as may be imagined, greatly interfered with sleep and nutrition. M. Leloir applied digital expression for the space of three minutes to the left phrenic nerve in the interval between the heads of the origin of the sterno-cleido-mastoid muscle, and definitely cured his patient, who had previously tried all the known anti-spasmodics of the codex. M. Leloir has since successfully applied his method in a large number of cases of chronic and recent hiccough which had proved refractory to other remedies. He states that he has not met with an instance in which this compression, exercised for a few minutes—sometimes only a few seconds—did not prove effectual.—Paris correspondent of *Lancet*.

TURPENTINE.

In an article in the *Lancet* urging the return to certain old-time drugs, Dr. Chapman says:

In 1873 I had a rapidly advancing case of purpura in a man twenty-five years of age, where hæmorrhage from the bowel was the symptom for which I was consulted. Never having previously seen a similiar case, I at first failed to recognize the disease. I gave a saline purge, and followed with lead and opium (examination of the rectum having given no evidence of local trouble), but to no purpose. Before long there was severe bleeding from all the mucous surfaces, and this, with the appearance of petechiæ on the general cutaneous surface, cleared up any doubt as to the nature and gravity of the complaint. Gallic and tannic acids proving of no more value than the preceding treatment, turpentine in twenty-minim doses every two hours was prescribed. The effect of the remedy was prompt and marvellous, the bleeding diminishing in a few hours and stopping entirely in three days. I saw this gentleman quite recently; he is in good health, and has never had a recurrence of this mysterious disease.

In the treatment of bleeding from uterine fibroids turpentine has with me been of great value, the drug frequently having succeeded when ergot, from lengthened use, appeared to have lost its effect, or the patient wearied with having taken it so long. In 1881, F. H—, widow, thirty-eight years of age, came under my care for excessive menstrual loss. The intervals of freedom from bleeding had been gradually getting less, and she was terribly anæmic in consequence. Physical examination revealed the presence of a large intra-uterine fibroid. Though the subcutaneous injection of ergotine was occasionally resorted to, the great beneficial effect was upon the bleeding. The patient was not allowed to submit herself to operative interference, though this was urged upon her; she has outlived her fibroid, and is now in the enjoyment of thoroughly good health.

In hæmoptysis, especially where there was much prostration, I have had reason to be satisfied with the hæmostatic and gently stimulating properties of the drug in question. Dr. Sydney Ringer, in the 1871 edition of his "Handbook of Ther-

apeutics" (p. 273), remarks of turpentine that "it is very efficacious in bleeding from the lungs, nose, uterus, kidneys and bladder." Yelk of egg and mist. tragacanth comp. are convenient vehicles for the drug, and when the patient does not object to it, I have found peppermint a useful flavoring. Turpentine has many uses beyond those here indicated, but my object was rather to revive an interest in this remedy than to fully discuss its uses. I may mention I have never seen severe bladder symptoms follow the exhibition of turpentine. If painful micturition happened to supervene, cessation from the use of the drug for a short time was all that was required.—*N. C. Med. Jour.*

TREATMENT OF NEURITIS.

In an article entitled "the recognition and treatment of the simpler forms of neuritis," Dr. McCaskey, of Fort Wayne, Ind. (*International Med. Magazine*, February, 1892) says:

Absolute rest of the affected nerve is the first indication. This means immobility of the muscular and other tissues through which the nerve passes, in order that there may be no irritation from pressure or motion. It also means absolute rest of all the muscles to which the various filaments of the nerve are distributed. If, for instance, the nerve-trunk involved is in the arm, motion of the fingers should be interdicted, whether it causes pain or not, because such motion cannot take place without calling into play the functional process of conduction, which is, of course, incompatible with the desired state of complete physiological rest. The nerve fibre can no more conduct impulses without molecular changes than a nerve cell can generate or send them out without this molecular disturbance. In the latter case it has been demonstrated under the microscope. To permit such molecular changes to occur in the fibres of an actually inflamed nerve is not remotely akin to throwing sand into the eyes in a case of ophthalmia. Absolute rest, even to the greatest possible disuse of the nerve-fibre, is what is meant, and it should be secured. Of course the limb should be placed in such a position as will most completely relax the parts around the nerve. In cases involving other nerves than those of the extremities, such modifications will have to be made as the circumstances require. The fact is, however, that with the exception of the nerves of the face, in nearly all of those cases involving isolated nerves, those of the extremities are the ones affected.

In this class of cases the free use of heat, in the form of a moist compress entirely enveloping the limb and covered with oiled silk, and outside of this hot flannels, has given me the best results. About twice or three times in the twenty-four hours, for periods of one or two hours, I have the compress maintained at as high a temperature as can be borne. The relief from pain is very marked in consequence, and patients generally get along with very little or no morphine. This course is only pursued until the most acute symptoms have subsided. If necessary for the relief of pain, opiates are, of course, employed, but they are dispensed with if possible.

The good effects of the faradic brush in the acute stage, admitting its temporary sedative influence, are, in my opinion, deceptive. Galvanism may possibly be of service in this stage, but, as a rule, I believe that electrical treatment had better be postponed until the acute stage has passed. I do not think that it is any more rational to stimulate an acutely-inflamed nerve with electricity than it would be to so stimulate an acutely-inflamed lung or joint. The time for electricity to be of service is after the acute stage has subsided, and the fibrinous exudations between the nerve-fibres remain as morbid products to be removed. Galvanism

here plays a valuable role. We should endeavor to be certain to include the inflamed segment of the nerve in the path of the current, even if one electrode has to be placed over the spine at a point near the origin of the roots of the nerve, and the other near its periphery. Whether the current is ascending or descending does not seem to make much difference. Indeed, the fact that the nerves are mixed, and convey impulses in both directions, would seem to indicate that one direction is quite as rational as the other for the use of the current. Its strength must be very mild—if a meter is used (and it should be), not more than one-half to one milliampere: if it is not used, then such a current as would be barely but distinctly felt. The seance should not last more than five minutes, and should not be repeated oftener than once every day or every other day. The exact time when the galvanic treatment should be commenced must vary in different cases—certainly not sooner, as a rule, than ten days or two weeks, and in many cases, where the inflammatory process is intense, it should be longer than this.

It is very doubtful if internal treatment has any marked effect upon the course of the inflammation, unless there is a syphilitic or rheumatic history, in which cases specific medication might be indicated. Unless there is positive evidence of the existence of these underlying conditions, however, such remedies should be withheld, as they would probably do harm rather than good. Even in the temporary paralysis following the acute disease, so eminent an authority as Julius Althaus does not place any reliance on internal medication. It would be then, if ever, that the alleged alterative action of these remedies should be of service in removing the residual inflammatory products. But here, as in the acute stage, local measures, combined with proper attention to the general health, constitute the best treatment.

GLANDULAR ABSCESS IN THE CRURAL CANAL SIMULATING HERNIA.

In the *Lancet*, December 19, 1891, Dr. Bennett reports several cases illustrating the occasionally deceptive nature of the symptoms of strangulated hernia. Of these the following is especially interesting:

A woman, thirty-six years old, was admitted into hospital on November 24th, 1890. She had always been in good health in every respect until six months before her admission. About that time she noticed a "lump" in the right groin, which varied in size occasionally, but never entirely disappeared. Sometimes after a hard day's work, the swelling increased very considerably. There was usually a feeling of discomfort, and often there was slight tenderness. A medical man who had once been called in attempted to reduce the tumor, and recommended that a truss should be used, which was, however, not done. On November 21st (three days before admission), the swelling, without any essential cause, became rapidly larger than it had ever before been. Pain and tenderness followed; vomiting commenced almost immediately, and recurred frequently up to the time of her arrival at the hospital. The bowels acted for the last time on the morning of the 21st. On admission the patient appeared to be very ill; the pulse was quick, the tongue dry, and the temperature 102·4°. There was copious vomiting of ill-smelling semi-stercoraceous material. In the right groin was a rounded mass as large as a full-sized walnut, tense, painful, and so tender that any accurate examination was impossible. The pain was apparently characteristic of a strangulated hernia, for it extended over the lower part of the abdomen, and, passing up from the right groin, it constantly dragged upon the umbilicus. A strangulated femoral hernia was therefore diagnosed, and what was thought to be a herniotomy proceeded with at once. After cutting down through some inflamed tissues, which bled freely, a rounded fluctuating swelling was ex-

posed, having none of the appearances seen about a hernial sac. From this there came, after incision, about two teaspoonfuls of thinnish pus with a small cretaceous mass, evidently from a caseating gland. The lining membrane of this abscess was easily scraped away, leaving a distinct capsule with clean walls. No hernia of any kind was found, nor had the abscess (which was distinctly made out to occupy the crural canal), any connection whatever with the peritoneal cavity. The plug of the connective tissue (septum crurale), in the femoral ring was intact, undisturbed, and entirely normal in all respects, proving conclusively that no hernia could have at any time existed at this spot. The wound was stitched up and dressed antiseptically as usual. Complete relief followed the operation. There was no subsequent vomiting; the pain ceased, and the temperature fell to normal. The bowels acted spontaneously in about forty-eight hours, and rapid recovery followed without a hitch of any kind.

SEED GROWTH AND ELECTRIC CURRENTS.

Some experiments, very simple, but of quite startling interest, are described in last week's number of the *Chemical News* (Feb., 5th). Dr. James Leicester, of the Merchant Venturers' Technical School, Bristol, has been studying the growth of seeds in what may be described as electrified earth. Scarcely any apparatus was used. A box about three feet long and two feet and a half wide was filled with soil, and near each end two metal plates, one of zinc, the other of copper, each about one square foot in size, were immersed, and were united outside by a copper wire. It is evident that by slow chemical action on the zinc a current will pass through the earth towards the copper, and returning by the outside copper wire will form about the simplest of simple cells. Various seeds were sown in the earth between the plates, and in every case it was found that the seeds grew much quicker than they did when the plates were absent. Similar and even more definite experiments were made with glass tanks, some with and some without the metal plates. All of them were fitted with the same earth, and were treated with the same quantities of water. In one typical instance the result is thus stated: "In the case of hemp seed, it was fully an inch above the surface before there was any sign of it in the ordinary vessels." The experiments were varied in several ways, but always with substantially identical results. It was found that if the soil was watered with a little very dilute acetic acid the growth of the seeds was much quicker when the metal plates were present, whereas without them no difference was noticed. Further researches on the growth of plant life are in progress, but have as yet yielded only negative results. It is impossible to anticipate the importance which may in the future attach to these remarkable observations. They have no analogy at all with the experiments of Dr. Siemens, also interesting and important, on the stimulation of vegetable growth by electric light. Everyone knows that electric light is closely analogous to solar radiation, and it is not wonderful that the work of the sun's rays can be imitated, if not equalled, by their only important rival, the voltaic arc. But in these experiments there is no question of light or heat radiation, but a subterraneous impulse imparted to the soil.—*Lancet.*

THE SANITARY NEEDS OF SAVANNAH.

The *Tennessee State Board of Health Bulletin* presents us with the following interesting statements:

It is matter of gratulation that while the State of Georgia is so lethargic as to be still destitute of a Board of Health, there are wide awake citizens in her great sea-port, as we learn from the report of the proceedings of the annual meeting of the Citizens' Sanitary Association held February 22. This body is composed of

prominent and active citizens, with a sprinkling of physicians as advisers and helps. It has a thorough organization, including a medical director, a consulting engineer, a sanitary engineer and an attorney, along with the usual officers. It has an executive council of fifteen members, men well and widely known beyond, no less than within the State.

The report of Dr. T. C. Le Hardy, the medical director, is elaborate and fearless, showing progress made, but also calling attention to imperative wants.

Dr. Le Hardy shows that Savannah may readily become the largest and most powerful city on the South Atlantic coast. "In this purpose we must certainly succeed if we can only prevent the recurrence of epidemic yellow fever, to which our city is liable. But should the precautions necessary to this end be neglected, should accumulations of filth be allowed to remain, should a hot summer come and find the drains clogged up, and that vast body of low lands around us saturated with moisture, all our endeavors are wasted, all the money we have spent thrown as it were in the fire, and the now thriving city will, in all probability, be called upon to face a calamity like that of 1876, when, with a bankrupt treasury, a decimated population, her credit destroyed, her reputation for health gone, she trembled on the verge of absolute ruin.

"The history of yellow fever shows that it has never raged here as an epidemic except when the summer's heat was intense and long continued, when the rainfall was excessive, the soil saturated and the city filthy.

"Soil saturation can be prevented by drainage, and all the filth can be removed.

"It is by their prevention and removal that cities north of us, formerly more liable to yellow fever than Savannah, have secured immunity from its visitations. It is certainly our imperative duty to employ the same measures if we wish to secure the same immunity."

The burden of this annual report is to show that the lands surrounding the city are now in a condition of excessive moisture; that the accumulation of filth in the city is beyond the belief of its inhabitants; and thereby to enlist the moral and material aid of all influential citizens to have these nuisances permanently abated as soon as practicable.

A thorough drainage system is urged with emphasis, and a clear account given of futile work heretofore done by the city and State, and a remedy for the past mistakes pointed out.

The questions connected with the vital topic of filth removal in all its forms are discussed, and practical reforms urged.

The report does great credit to all concerned. It is evident that the people of Savannah have not been asleep of late years, and that her leading citizens are determined that no steps backward shall be taken. Where there is plain speech and no whitewashing there will sanitary progress be genuine and permanent.

The first commencement of the Training School for Nurses of the Maryland University was held May 4th. The graduates who have been taking the two years' course are Misses Anna Edith Lee, Anna Louisa Schleunes, Amelia Neil, Lelia Dunham, Mary Elizabeth Goldsborough, Catharine Crane Lucas, Edna Durham and Janet Hale. The exercises began with prayer by Archdeacon Moran. An address was made by Prof. S. C. Chew. The diplomas were awarded by Dr. I. E. Atkinson, and benediction was pronounced by Rev. Dr. Julius E. Grammer.

Recommendations of Therapeutic Agents.

THILANIN, (BROWN SULPHURATED LANOLINE.)

In a paper read before the Third Congress of the Dermatological Society at Leipzig, September, 1891, Dr. Edmund Saalfeld, of Berlin, says:

Some medicines formerly used have been rejected in consequence of their impurity, notwithstanding their partially recognized usefulness—for instance, a preparation that is now almost obsolete, sulphur balsam (oleum lini sulphuratum) was formerly used in many external ailments. Considering the well-known qualities of sulphur, which has been utilized, in numerous remedies, the preparation of some chemical compound exhibiting the useful qualities of the old remedy, without possessing the disagreeable ones, was desirable, or, in other words, to be able to combine, as in the oleum lini sulphuratum, the efficacy of the sulphur with some non-irritant, neutral fat was of paramount importance. Such a compound has been obtained, by the reaction of sulphur upon lanoline, by Seibels, a chemist, employed in the extensive works of Benno, Jaffe & Darmstaedter, Martinikenfelde, near Berlin, in this substance, which is called Thilanin. It is as yet undecided in which way the sulphur has combined, there being two possibilities; it may have combined with the cholesterine or with the fatty acids. But although this question is undecided, this substance is, according to the mode of preparation, as published, a true composition containing 3 per cent. of sulphur. It is of salve-like consistency, as ordinary lanoline of a brownish color, and its peculiar odor at once suggests the idea that sulphur is one of its constituents.

Its use in general is indicated in dermatoses, in which the thilanin is to be substituted for an indifferent ointment, which would at once facilitate a cure by more energetic action. This remedy is therefore meant to take the place of the commonly used ung. Hebræ, to which, owing to certain qualities, it is vastly superior.

Its advantages over the various officinal indifferent remedies are, that its effect is more energetic, *i. e.*, that it is absolutely non-irritating, and that therefore it may be applied without danger in all cases, where we were forced heretofore to use different remedies, with which the desired result could not be obtained, and often very disagreeable effects were observed. In a large number of cases of skin disease, the itching sensation was reduced by using this remedy. The use of undiluted thilanin on the hair-covered parts of the scalp seemed to be contra-indicated.

UNITED STATES CIRCUIT COURT, Eastern District of Louisiana.

(*Battle & Co., Chemists' Corporation, vs. Finlay & Brunswig.*)

This cause came on to be heard at this term, and was argued by counsel; and thereupon, upon consideration thereof, it was ordered, adjudged and decreed, as follows, viz:

"That complainant has an established property right in the word "Bromidia," as a trade-mark applied to a certain liquid medical preparation mentioned in the bill of complaint herein, and that defendants have infringed the rights of complainant in the said trade-mark."

That the injunction issued pendente lite be maintained, and the defendants, George R. Finlay and Lucian N. Brunswig, co-partners, doing business under the firm name of Findlay & Brunswig, and each of them, their clerks, servants and employees, be restrained and prohibited from printing, affixing or using the word "Bromidia," or any imitation thereof on the label of any medicinal or chemical

preparation, or applying the name or title "Bromidia" to any medicinal or chemical preparation, and from offering for sale or giving away any bottles or packages marked with said word "Bromidia," or any imitation thereof, other than the preparation manufactured and labeled by the complainant; and it is ordered that the parties be referred to J. W. Gurley, Master, to take an account of the profits made by the defendants in manufacturing and selling, and in selling any medicinal or chemical preparation under the name, mark or title of "Bromidia," or upon which the name, mark or title of "Bromidia" was printed or written, or to which it was applied by them, since the first day of January, 1886; and for the better taking of the same discovery of the matters aforesaid, the said George R. Finlay and Lucian N. Brunswig are ordered to render an account of the number of packages aforesaid sold by them, and of the prices at which sold and prime cost thereof; and to produce before and leave with said master, all deeds, books, papers and writings in their custody or power relating thereto, and are to be examined as said master shall direct; and that they be ordered and decreed to pay to complainant the profits of all such sales made by them, and all costs of this suit.

(Signed), April 23, '92. Edward C. Billings, Judge. E. R. Hunt, Clerk.

Medical Items.

The following gentlemen of this city will read papers at the next Annual Meeting of the Association of the American Physicians, to be held in Washington, D. C., May 24, 25, 26, 1892. Dr. Wm. T. Councilman, "Etiology and Pathology of Dysentery." Dr. S. C. Chew (subject not announced). Dr. Thomas S. Latimer, "Alcoholism." Dr. Francis T. Miles, "A Case Presenting the Symptoms of Landry's Paralysis, with Recovery."

The American Surgical Association will meet in Boston, May 31st and June 1, and 2, in the Hall of the Natural History Society on Berkeley St. The following special subjects for discussion are announced: "The Treatment of Uncomplicated Fractures of the Lower End of the Humerus and of the Base of the Radius," by John B. Roberts, M. D. Discussion by Drs. John E. Owens, of Chicago; John H. Packard, of Philadelphia; C. B. Porter, of Boston; and J. Ford Thompson, of Washington, D. C. "Fibroid Tumors of the Uterus," by John Homans, M. D. Discussion by Drs. F. E. Lange, of New York; M. H. Richardson, of Boston; A. M. Vander Veer, of Albany; J. Ewing Mears, of Philadelphia; and George R. Fowler, of Brooklyn. "Surgical Operations in Persons Suffering from Diseases not connected with that necessitating the Operation, such as Chronic Malarial Poisoning, Diabetes, Organic Heart Disease, etc.," by W. T. Briggs, M. D. Discussion by Drs. T. F. Prewitt, of St. Louis; Hunter McGuire, of Richmond; and W. W. Dawson, of Cincinnati. "Surgery of the Tongue," by N. P. Dandridge, M. D. Discussion by Drs. D. W. Cheever, of Boston; D. W. Yandell, of Louisville; and L. McLane Tiffany, of Baltimore. "Conditions demanding Excision of the Globe of the Eye," by W. H. Carmalt, M. D. Discussion by Dr. Wm. Thompson, of Philadelphia, Pa. "Ancient Contractures of the Hip and Knee Joints," by T. F. Prewitt, M. D. Discussion by Drs. DeForrest Willard, of Philadelphia; and Robert Abbe, of New York. "Report of Operation upon Spina Bifida and Encephalocele, with remarks," by A. T. Cabot, M. D. The Association will meet on Wednesday morning, in the Amphitheatre of the Massachusetts General Hospital, and on Thursday morning in the Amphitheatre of the Boston City Hospital. Phineas S. Connor, President, J. R. Weist, Sec'y.

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CONTENTS

ORIGINAL ARTICLES.

Aphasia, with Report of a Case. By J. T. King, M. D., Baltimore. 639

Abortion; Its Increase, Effects Socially, Treatment, Etc. By J. H. Kennedy, M. D., Aberdeen, Md. 642

Does Organic Disease of the Heart Preclude the Use of Chloroform in Parturition? By T. Ridgway Barker, M. D., Philadelphia. . . 644

SOCIETY REPORTS.

Clinical Society of Maryland. Stated Meeting held April 1, 1892. Mechanism of Axis Traction Forceps. Death Following Supra-Pubic Aspiration of the Bladder. Idiopathic Pericarditis. 647

EDITORIAL.

Journal Clubs. 652

Carlsbad. 653

REVIEWS, BOOKS AND PAMPHLETS. . . . 654

MEDICAL PROGRESS.

Some of the Rarer Complications of Rheumatoid Arthritis.—A New Musical Instrument.—The Uterine Catarrhs of Young Girls.—The Couch.—Rupture of the Uterus Caused by Divulsion. 654

MEDICAL ITEMS. 659

Original Articles.

APHASIA, WITH REPORT OF A CASE.†

BY J. T. KING, M. D., OF BALTIMORE.

Aphasia is defined as "an impairment of the idea of language, or its expression, independent of paralysis of the tongue." It is commonly described as of two varieties (though a number of other divisions have been made), the amnesic, or sensory form, and the motor or ataxic form. In the former, memory of words or symbols is more or less effaced, so that the subject may misname the most familiar objects, though he may at the same time be aware of his error and his inability to correct it. In the motor or ataxic form the memory may be perfect, though the subject cannot pronounce the words from an inability to perfectly co-ordinate the muscles used in articulation. Now, the case before us is, in my opinion, a case of amnesic aphasia.

Some patients forget only names, others only numbers, some retain the name of a thing only in a dead or foreign language, others again lose all knowledge of a foreign tongue. In the ataxic form the patient can usually write what cannot be spoken, thus showing that the difficulty is not loss of memory of words, but rather the inability to so co-ordinate the muscles of articulation as to properly pronounce them. Charcot reported a case where a patient could write with ease, but could read only by retracing the lines with his finger. In true motor aphasia the patients cannot articulate correctly, a fact of which they are painfully aware, and remain mute; but often when they retain or recover a word or expression

†Read before the Baltimore Medical Association, April 25th, 1892.

they use the same under all circumstances, though absurdly irrelevant to the question asked. Hammond reports a case where the patient's unvarying remark was "Hell to pay." Another would reply to all questions, "I want protection," etc.—His political affiliations are not mentioned.

By word deafness, which is a form of sensory aphasia, is meant not an inability to hear spoken language, but an inability to appreciate the value of certain sounds. This condition prevents the patient from speaking correctly, because he cannot recall the proper sound of many words employed by him previously. His effort to read aloud will result in his giving utterance to the most ludicrous jargon of unintelligible sounds. The patient will read solemnly and in good faith, not knowing that his utterances are unnatural or inexpressive of the idea he wishes to convey. This is exactly the condition of the patient before you. One such person was asked to read aloud the sentence "You may receive a report from other sources of a supposed attack on a British Consul-General; the affair is, however, unworthy of consideration." As nearly as could be taken down this is what he uttered: "So sun wisjee cay wenement apripsy forfency fenement why a secrence cos for no saphias a the freckled pethy conalloid. This affair eh oh cont oh curly af consequences."

This patient could not write to dictation, but could copy accurately and write his name. In making each letter, however, he would attempt to name it aloud, but always pronounced some other letter. This is exactly true of the case before you.

Word blindness is accompanied by a loss of memory of the meaning of printed or written symbols. Patients thus affected cannot properly read a given selection. They often write from dictation but cannot read what they have written. Dr. Ranney reports a case where the patient, when called upon to read aloud, would make the most careful preparations, putting on his spectacles and taking some time in adjusting himself properly. Then he would read, saying things without the slightest connection with the text before him. He was asked to read the following note: "Dear Sir: I shall be much obliged if you will let me know whether or not you consider it likely that A. B. will recover." He looked at it carefully, then slowly and deliberately he read: "Dear Sir: you are requested to bring this note with you to the infirmary."

As a number of points as to causation, location of lesion, treatment, etc., of aphasia are referred to in narration of case, I will here take it up.

Case of aphasia.—I am very glad, gentlemen, to bring before you this evening this interesting case of aphasia. The subject, as you see, is a gentleman of fine physique, with a remarkably well developed brain, as manifested in an intelligent face. He is an expert accountant, called upon to unravel the intricacies of business complications. Being well educated, it will be easier in his case to study the impairment of the intellectual faculties, and to observe the various manifestations. His earlier history fails to assist me in understanding his present condition, for as far as I can learn there has been no former paralysis, affection of the heart, nor specific disease.

Two months since, on the twenty-first day of February, I was called to see him in an attack of right hemiplegia. It is interesting to note that the paralysis was upon the right side, for it has been observed that it is this side in a very large majority of cases which is affected where aphasia is complicated with paralysis, thus fixing the lesion upon the left side of the brain and assigning to that portion the speech centre. In not an inconsiderable number of cases, however, aphasia may be associated with left hemiplegia. A case where a tumor of the

third right frontal convolution was found in a case of aphasia is reported by Habershan (*Med. Times and Gazette,* 1881), while Trousseau also gives a case which he claims to be the first on record, where aphasia is associated with left hemiplegia. This case I shall give more fully at length. But as neither of these gentlemen state that their patients were left-handed, it may have been, as Hughlings Jackson asserts, that "the relationship of aphasia to the side which is congenitally preëminent, and which is in the vast majority of human beings the right side, is not destroyed by a partial education of the other side to such acts as writing or using of the knife."

The paralysis in our case very soon disappeared; in a day or two he had the usual control of his muscles, but with the recovery from paralysis we find he has not recovered his speech. Not that his tongue was not perfectly mobile, not that he was unable to see or even to understand words. His hearing was not impaired, he paid close attention to me when I addressed him, his face gave evidence of intelligence, yet he could not speak. I placed a pencil in his hand, and though he held it correctly, and had full use of all his muscles, he could not write any words.

True, he formed letters, but he did not arrange them into words. During the past two months he has added a few words, can write his own name, but when I ask him to spell the same, even when he has his own written words, he does not call the letters correctly, and adds many not contained in the text. A day or two since he said distinctly to me, "Doctor, walk in and take a chair, for I know that you are tired." These words I could not induce him to repeat, though I tried assiduously.

On another occasion I asked him the hour; he said "five minutes of five." The correctness of his statement was verified by my consulting my own watch. He made me understand that at times when persons ask him the hour, though he may read on the face of his watch "five minutes of five" he would as likely say, "twenty minutes of ten," or "fifteen minutes of eleven" or any other hour, at the same time knowing it was incorrect, but feeling his inability to correct it. His eyes told him one thing, while his lips repeated another. This seemed to annoy him very much.

Mr. M., please read this note: "This hall is occupied on the second and fourth Monday of each month by the Baltimore Medical Association, the oldest local society in the city; also twice each month by the Clinical Society, a young, but a vigorous, energetic organization. To-morrow the Medical and Chirurgical Faculty of the State of Maryland will hold its ninety-fourth annual convention in this building."

I am persuaded that he understands what he reads, though we could not if we depended upon his pronunciation. Early in his illness this expert accountant, who could in health, with the greatest rapidity, add up long columns of figures, could not add 2 and 2 correctly. Now he can do better. Mr. M., please add 136 and 287 on the black board; also 112, 216, 173.

You see he has some knowledge of figures, though it is very imperfect.

He cannot write from dictation, though he may transcribe a few words from a copy. He has lately learned to write his own name, but when called upon to spell the same, he miscalls all the letters, and adds many not contained in it. Sometimes, when I hold an object before him and ask what it is, he may give the object the correct name, or it may be a name unheard of, or it may be a name somewhat resembling the correct one.

I will not test him at this point, but the members may after I have finished.

What lesion have we to contend with in this case? This question may not be answered satisfactorily, but it is probably either hæmorrhage, tumor, or thrombus plugging the middle cerebral artery of the left side.

Among the other recognized causes of aphasia we have syphilis, ligation of the left carotid artery, gout, various conditions of debility and often acute diseases. It has been seen after chloroform narcosis, after santonin (5 cgr.) and after fright; and is said to be one of the ordinary symptoms after the bite of venomous serpents. I have found a report of one case where aphasia was congenital in an intelligent subject.

Location of lesion: It is now generally conceded, I believe, that the seat of the faculty of articulate language is found in the second and third convolutions of the left anterior lobe of the brain.

Treatment: Our "Emperor," Smith, once said, If you do not know what to give, order iodide of potassium. This has been my treatment in this case, with ergotole, I hope not without reason.

ABORTION; ITS INCREASE, EFFECTS SOCIALLY, TREATMENT, ETC.*

BY J. H. KENNEDY, M. D., OF ABERDEEN, MD.

It has been my experience of late to encounter an unusual number of cases where utero-gestation was interrupted in the early stages. This fact has led me to believe that abortion from whatever cause or however brought about is increasing and that it is an important factor in the so-called "limitation of families," to which I wish briefly to refer. I shall not concern myself with the moral obliquity of the case, nor attempt to prove that this "limitation of families" is a product of our advanced civilization. "Through the ages one increasing purpose runs, and the thoughts of men are widened with the process of the suns." Let us hope that this broader, higher, intellectual state is not one inimical to childbearing and the endearments of maternity.

France to-day, great in the arts of war and peace, has the curse of being almost a childless nation; its great men, thoroughly aroused, look with consternation upon the situation and are using all legitimate means to avert the impending evil. This recalls the words once uttered by the great Corsican: "She is the greatest woman in France who rears the most numerous offspring." Shade of Napoleon! Could you but see your beloved France to-day! The literature upon the treatment of abortion so far as its prevention goes, is not meagre, but I find very much less said concerning the treatment of cases wherein there is no longer any doubt that the embryo has perished. In fact, I think that often they do not receive the attention that their gravity demands, nor do we always realize the extent of their morbific influence upon the special organs, as well as the general health of the individual. I believe the gynæcologist derives as many of his brilliant operations for the "removal of the appendages," etc., from the sepsis of neglected abortion as he does from gonorrhœal infection. Often the physician is not called at all or the woman is not aware that anything unnatural has happened, though her symptoms are unusual and probably she may have missed one or more menstrual periods. From habitually regarding such occurrences as trivial, or sometimes coming to desire or even procure them, women will seldom confine themselves to bed or observe other proper hygienic rules unless compelled by pain and hæmorrhage or enjoined by the physician. Very many abortions occur where

*Read before the Medical and Chirurgical Faculty of Maryland, April 26, 1892.

from some cause the membranes are ruptured and a portion only of the contents are discharged. It is to this class of cases that I desire to call your attention. Some placental debris remains, giving rise to pain, hæmorrhage, etc. Again, such an accident may have happened, and there may be some doubt as to the exact condition, from the symptoms, unless an examination be made; however, such being the case, unless in very robust women, nature is unable to tide over the disability and we are not left long in doubt that there is something wrong. The temperature is elevated, acrid discharges sweep away the healthy cervical and vaginal mucus and set up erosions, leucorrhœa, etc. A plant, so to say, is established for the evolution and dissemination of morbific germs by direct continuity of structure or by absorption.

The recent developments in bacteriology teach us very plainly that all forms of metritis, endometritis, cervicitis, and even subinvolution, though distinct in themselves, are alike microbic in their origin. In recent cases where the woman is losing blood, and there is no doubt of the death of the embryo, no expectant plan of trusting to ergot, employing the tampon, ice, etc., should be adopted.

Ergot under the circumstances is a poor staff to lean upon, and the tampon unless frequently replaced is septic and highly dangerous, and at the same time, uncomfortable and often useless. In all cases, whether recent or of long standing, the interior of the uterus should be explored by the finger, or better, the curette, and its contents removed.

The method I usually pursue is to place the woman in the position for perineal operation, and with the bimanual method of forcing down the uterus with one hand externally and invaginating with the other, introduce one or more fingers as the os may admit. Failing in this, or in preference to the above method, use the dull curette. Retract the perineum with a Simon's or Jackson speculum, and draw down the uterus to the vulva and retain it there. The curette is now employed and the endometrium thoroughly scraped until the interior of the uterus is as smooth as the inside of the cheek, if possible. Your sense of touch will soon tell you when you have cleared away all adhesive matter. Draw out with the curette all the debris possible and if the condition is septic flush out the uterus with sterilized water or salt solution—1 drachm to the liter. Many employ a five per cent. carbolic acid or 1-5000 bichloride solution, but there has arisen considerable doubt about their safety, though lauded by many eminent authorities. In addition to the douche it would be well in septic cases to apply Churchill's tincture of iodine pretty freely to the interior of the uterus. Daily vaginal douches of hot water or antiseptic solution should be used until the discharge ceases. Goodell warns us against the curette as giving rise to hæmorrhage by partially separating the mass. I have found that such is the case where the mass is of such volume that the curve of the curette will not span it and reach the endometrium. Then the placental forceps should be used to seize and tear away or twist off the bulk, after which the curette will remove the remainder completely. I have had but little trouble with subsequent hæmorrhage and do not remember ever to have used any means to control it. The action of the dull curette is that of massage and stimulates the uterus to contraction; some writers advise packing the uterus with iodoform gauze, others injecting it with strong vinegar to control bleeding, both of which are valuable means, though in regard to the former, the gauze when soaked with blood hinders drainage, and the uterus resists its presence as a foreign body. If hæmorrhage continues or be more than a pinkish discharge after 24 to 48 hours, probably there is some debris remaining which will demand a second curetting. It may be necessary in some

cases to employ anæsthesia, particularly if you are obliged to use the dilator, as in cases of long standing. This is about the course of treatment I have pursued, with the addition of ergot as an after-treatment, and an opium suppository at the time, when demanded. The patients invariably experience marked relief almost immediately after the operation; convalescence is uneventful and usually continuous.

And now a word in reference to antiseptics. It would be well, in fact, a blessing, to all parturient and other women undergoing operations or examinations of the vagina and uterus, if the medical attendant and nurse could be compelled to obey the warning "*nolli me tangere*" with unclean hands, instruments or appliances. Render your hands as aseptic as possible by scrubbing with a brush and soap, paring and cleaning the nails and immersing in a 1-500 bichloride solution and then in alcohol or ether. If you have solutions of permanganate of potash and oxalic acid, for the same purpose, so much the better. Sterilize your instruments by steam or hot water. Practicing in the country, as many of us do, the antiseptic system is difficult to carry out. It may be accomplished without much expense and at the same time be practical. A canvas telescope satchel, some screw-top, wide-mouthed bottles to hold solutions of oxalic acid and permanganate of potash, a bottle of bichloride tablets, and carbolic acid. The wide-mouthed bottle will admit one finger at a time and save the necessity of using basins for the solutions of acid and potash. I am aware that a physician so equipped is a "stirring object," either in my lady's chamber or at the bedside of the humble patient, but it is better to err, if we must, on the safe side, having the consciousness of duty faithfully performed.

DOES ORGANIC DISEASE OF THE HEART PRECLUDE THE USE OF CHLOROFORM IN PARTURITION?†

BY T. RIDGWAY BARKER, M. D.,
Demonstrator of Obstetrics in the Medico-Chirurgical College, Philadelphia; out-door Obstetrician to the Pennsylvania Dispensary.

In entering upon the discussion of a subject of such paramount importance to mother, offspring, and obstetrician, one cannot lay too much stress at the very outset upon the axiom that "A good remedy will fail of its effect, if not properly administered." This fact must be kept uppermost in our mind if we would avoid fatal results, not due, however, to the employment of the agent, as some would make it appear, but to the lack of attention and care exercised in its administration. That there is a radical difference between surgical and obstetrical anæsthesia (analgesia), goes without saying. If we consider for a moment the stages of anæsthesia, which differ only in the profoundnees of the impression—first, sopor; second, stupor; and, third, stertor—we cannot fail to notice that in analgesia one rarely has occasion to carry the effect beyond the first degree (sopor), while in the surgical variety we are obliged to advance beyond this and keep the patient in the second stage, or that of stupor, thus markedly increasing the gravity of the prognosis.

In this connection, let us devote a moment's consideration to the progressive effect of chloroform vapor upon the nerve centers of the cerebro-spinal system, beginning, as it does, at the inferior extremity of the cord, sacro-lumbar, and gradually extending its paralyzing influence upward until it reaches and expends its force upon the medulla oblongata. These well established clinical observations

†Read before the Philadelphia County Medical Society, April 27, 1892.

having been verified by physiological experiment, we are justified in putting them to practical use. What other agent, may be pertinently asked, can relieve—aye, abolish—pain so quickly and safely, yet leave reflex muscular contractility unimpaired, as chloroform? Ether and ethyl bromide have found favor with some practitioners, but neither can displace chloroform.

Fordyce Barker states in his writings: "I may say here that I have long regarded chloroform as the best and safest anæsthetic in obstetrics, and that since 1850 I have used no other."

The danger from the employment of chloroform in this department of medicine depends more upon the carelessness with which it is administered than upon any toxic effect inherent in it. The four cardinal points to be borne in mind when giving this anæsthetic are: First, plenty of pure atmospheric air: second, liberation of of a small amount of the vapor at a time: third, attention to the respiration; and fourth, frequent observations as to the force and frequency of the cardiac action. That the recorded cases of death have been due in a great measure to saturation of the residual air in the lungs to a fatal degree can scarcely be doubted. A few deep, forced inspiratory efforts will quickly produce such a condition. Withdrawal of the agent under these circumstances cannot prevent the further entrance of the chloroform vapor into the circulation, for it already fills the air-cells. Nor will attempts at artificial respiration prove effectual, since but a small quantity of the residual air can be forced out of the lungs, while that which enters fails to sufficiently dilute the vapor owing to the tardiness of diffusion. Let us not suppose, however, that because we administer to the parturient female small amounts of the drug continuously, therefore no risk is incurred, for experiments directed to solve this important question go to prove that even small doses, when continuously inhaled, tend to produce dangerous, and at times fatal, cardiac exhaustion. Far different is the result when given intermittently, as is the unalterable rule in obstetrics. Should we seek authority for the statement that the dangers from the careful administration of chloroform in labor are too insignificant to warrant its refusal, we have only to turn to the *American System of Obstetrics* to find therein the following: "The danger when chloroform is used only to the extent of mitigating or abolishing pain in childbirth is practically *nil*." Lusk, quoting from Bert's experiments, states, "that chloroform might be intermittently administered for an indefinite period with safety." These remarks do not apply to its use in the third stage of labor, for, as is well known, after delivery of the child it is likely to occasion relaxation of the uterus, thus favoring post-partum hæmorrhage.

Offering the above as a preface to my remarks on the judiciousness of employing chloroform when the parturient female suffers from organic cardiac disease, it now remains for us to consider the effect of parturition upon this enfeebled circulatory organ; thereby securing a scientific basis for our conclusions. In the first stage of labor we find the muscular contractions confined to the uterine muscular layers and directed toward overcoming the circular fibres of the cervix, while in the second or propulsive stage not only does the uterus exert its power to the utmost, but also the abdominal and respiratory muscles are brought into action by the will of the parturient in her efforts to expel the fœtus. The diaphragm is forced down and its movements paralyzed by the female holding her breath.

The other respiratory muscles are likewise unable to act, and hence imperfect oxidization of the blood results. As a consequence, the cardiac movements are accelerated, greater resistance is met with in the pulmonary and aortic circula-

tions. Moreover, a tendency exists to venous congestion, as evinced by the hue of her face and swollen veins.

Owing to the excruciating pain experienced when the head passes through the cervix, the parturient is further tempted to make additional muscular efforts, which only augment the difficulties met with. Under normal conditions this strain is of such brevity that it cannot be considered of any importance, but when complicated by disease of the heart it is of far greater gravity. If the condition be one of fatty degeneration due to a previous peri- or myocarditis, resulting in faulty nutrition and enfeeblement of the heart's action, as evinced by weak impulse, venous stasis, confused and irregular sounds, anæmia alike of brain and other organs, with faintness and oppression on the slightest exertion, this interference with circulation and respiration may readily tax its powers too far, and so cause speedy death from paralysis. Here the conditions which pertain in surgical anæsthesia are absent. The indications present are to allay excessive muscular action and respiratory spasm which is threatening the over-stimulated heart.

To allow the female to continue such efforts is to permit her to commit suicide: to warn her to desist is useless when in such agony; while delay is likely to be fatal. How can we overcome this condition of nervous excitement? Can we accomplish it by the administration of chloroform? Yes: of the two evils, for we must acknowledge there is an element of risk in giving chloroform, we can only choose the lesser, and so promptly proceed by inhalation to relieve the accessory muscles of parturition of their strain. By the abolishment of pain we lessen the work required of the laboring heart, which, instead of beating at the rate of one hundred and forty or more a minute, may diminish in frequency to ninety or one hundred.

What has been said of fatty heart is equally applicable to conditions of hypertrophy and dilatation.

The equilibrium, if disturbed, is almost certain to result disastrously. That sense of fullness in chest and oppression due to bronchial congestion, if relief is not afforded, becomes most distressing. The cyanosis from deficient aëration is greatly exaggerated, while the insufficient blood-supply to the brain causes syncope and may be succeeded by coma if the excessive reflex disturbance be not removed. Nor are the indications for the administration of chloroform materially different in the case of females in labor with valvular disease. Whether it be mitral in the young adult or aortic in the aged primipara the cardiac strain must be relieved if we would save our patient. As is well known, all forms of valvular disease ultimately develop a condition of ischæmia on one side with corresponding low tension, while on the other side is stasis with high tension. While by compensation life may run on for years, yet, when the strain of parturition comes it will soon be overthrown if precautions are not taken to prevent it.

Of what benefit will be our knowledge of the value of cardiac "physiological rest," as laid down by Fothergill, if we do not apply it under these conditions? We all appreciate the importance of securing "quietude of mind and body" when such pathological states exist. Then why not employ the quickest and safest means to obtain it by the inhalation of chloroform? If the danger is great from "active exercise—climbing mountains, running up stairs, lifting heavy bodies, and all kinds of exercise involving heart strain"—how much greater, aye, how immeasurably so must it be when the parturient female forces, with the anguish of despair, every muscle to its utmost in her desire to deliver her child. From a study of chloroform anæsthesia in obstetric practice we have seen how it should be administered and how it acts. Surely none will deny that in its em-

ployment under these circumstances we act otherwise than for the best interest and safety of our patient. That one may not be charged with being a blind adherent to theory, one has only to turn for support and justification to the teachings of the late lamented Fordyce Barker, who states: "It seems to be almost accepted as an axiom, with both the profession and public, that the inhalation of chloroform is dangerous for any woman with disease of the heart. For more than thirty years I have been convinced that this opinion is quite erroneous, and I have so taught in my lectures and in former writings."

He goes on further to say: "I have seen several cases, complicated by dangerous heart lesions, which terminated favorably, as I think, solely from the use of chloroform."

Snow, likewise, is of this opinion, "In all forms of valvular disease," he says, "chloroform, when carefully administered, causes less disturbance of the heart and circulation than does severe pain." To quote from Championnière: "If," he says, "I recognized an organic affection of the heart, without pulmonary complications, I should rather give the woman chloroform than to let her suffer." Were further proof necessary as to the propriety of emplying chloroform anæsthesia, one might include among this group of clinical observers, Vergeley, who expresses himself thus: "Diseases of the heart are not a contra-indication to the use of anæsthesia." Macdonald states: "In almost all cases of heart disease with labor chloroform has been given, and apparently with benefit, during delivery. If carefully administered I think it cannot but be useful in all cases." Since such eminent authorities advocate its employment, can we justify ourselves in refusing our patients the benefit and comfort this agent affords? What is the danger from chloroform compared to the state of exhaustion and collapse into which the parturient female will inevitably fall? If this heart is forced to the verge of paralysis from overwork and excitement, why shall we not use the means at our command to lessen that strain? Let us have a reason for the faith that is in us, and not hesitate to fearlessly employ extreme measures to overcome extreme dangers.

Chloroform by inhalation can and will, if properly administered, save the lives of parturient females, suffering from organic disease, when death seems imminent from over-stimulation of its ganglia through reflex nervous action. Organic heart disease, then, does not preclude the use of chloroform in labor, but rather is a condition calling for its careful administration.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD APR. 1, 1892.

The 265th regular meeting of the Society was called to order by the President, Dr. Robert W. Johnson.

Dr. Wm. S. Gardner read a paper upon THE MECHANISM OF AXIS TRACTION FORCEPS. A pair of forceps designed by the author were exhibited.

Dr. Frank Dyer Sanger read a paper on DEATH FOLLOWING SUPRA-PUBIC ASPIRATION OF THE BLADDER.

The patient was 75 years of age, white, large, rather fleshy, full habit. Had had trouble passing his urine for some time but never retention. For three days he had suffered much pain in the region of the bladder and could only pass a small quantity of urine at a time. Examination showed the bladder to be mod-

erately distended, its summit about two inches below the umbilicus. A hot bath gave no relief. A number of strictures were found in the urethra; nevertheless a long curve catheter was passed as far as the prostatic urethra, nothing could be passed further. Seven hours after the patient was first seen, aspiration was determined upon as I felt sure the bladder would suffer if not soon relieved. A double inguinal hernia and a rather thick accumulation of fat over the pubes decided me to insert the needle well up. Having used thorough antiseptic precautions, I felt that I could pass a needle through the peritoneum with safety. About one quart of urine was removed from the bladder. A drop of blood followed the removal of the needle; the point of puncture was covered with a strip of adhesive plaster and the patient went to sleep. Next day his bowels moved freely, and he passed considerable urine, a part of which escaped into the bed and could not be measured. The morning of the second day after the operation he complained of pain in the lower part of the abdomen and tenderness. Bladder could not be felt; pulse somewhat accelerated; temperature normal. Toward evening abdomen became tympanitic, pulse more rapid, temperature 98, expression anxious, urine passed in small quantities. Bladder could not be made out. Opium given to relieve pain and heat applied to abdomen. Patient died next morning, 62 hours after the aspiration.

Post-mortem: Needle had entered the abdominal wall two inches above the upper border of the symphysis pubis. A line of light extravasation marked the track of the needle through the wall and parietal peritoneum fold; further than this its track could not be positively determined as the pelvic cavity was filled with blood. Dense adhesions bound the bladder in all directions, which required considerable force to be broken up. There was considerable redness of the parietal and visceral peritoneum in the vicinity of the bladder. No pus or urine apparently. In freeing the adhesions about the bladder, that organ was ruptured and about one-half pint of turbid urine escaped. I removed the bladder and urethra *en masse* but was prevented from further examination by friends who came to claim the body. I regret that I did not at least secure one of the kidneys, as it might have thrown some light on the cause of death.

There have been a number of deaths reported from supra-pubic puncture for the relief of a distended bladder. Deneffe and Van Wetter in 1877 collected 152 cases of supra-pubic puncture with 6 deaths; 87 cases of rectal puncture with 11 deaths. I have not been able to find another case of accident from aspiration in the literature, though my search has not been by any means exhaustive. Deneffe and Van Wetter report 57 cases of aspiration with no accident, showing the improvement upon puncture. The case here reported proves at least that aspiration is not free from danger and suggests greater circumspectness in its practice.

Dr. W. P. Chunn: In these cases of distended bladder by sticking close to the symphysis you can get into the bladder without striking the peritoneum at all, and this is what most operators attempt to do. In this case under consideration some urine probably trickled out of the bladder and gave rise to peritonitis.

Dr. J. W. Chambers: I begin to look upon every case of greatly distended bladder in old men with enlarged prostate with a certain amount of apprehension. The condition is a dangerous one. The case in point is interesting from the amount of hæmorrhage that followed a simple aspiration. The condition of the veins over the front of the bladder can be very aptly compared to the condition of the veins in front of the trachea where we frequently meet irregular veins which give rise to considerable trouble in operations. In the present case, with an enlarged prostate interfering with the circulation, the veins on the anterior

surface of the bladder were doubtless distended, and probably all of these varicose veins were punctured, giving rise to the hæmorrhage. The peritoneum was probably infected by the needle, which became infected in the bladder. Ordinarily a puncture two inches above the symphysis, when the bladder is distended, would not strike the peritoneum, as there is then usually 2½ to 3 inches space between the symphysis and the peritoneal reflection.

Dr. S. K. Merrick read a paper on IDIOPATHIC PERICARDITIS, with report of two cases. The term idiopathic pericarditis is used by authors to define an inflammation of the pericardium (which may be acute, sub-acute or chronic) not the result of any discernible preceding or concomitant pathological process. To eliminate every etiological factor in any given case and by exclusion arrive at a diagnosis of idiopathic pericarditis requires no little pains on the part of the practitioner. Not a few authors are skeptical as to its existence. DaCosta, while admitting its extreme rarity, says he has seen several cases about which he has no doubt as to the diagnosis. It may be that the paucity of cases of this affection reported depends in no small degree upon the obscurity of the symptoms and latency of the affection, which may possibly be characteristic of this form of pericarditis.

CASE I.—Widow, aged 60, came under observation at the Northwestern Dispensary in the early part of 1887. Complained of pain in the precordial region, of great weakness and faintness on exertion and that her hands and feet were always cold. She had had no acute illness for years. Never had rheumatism nor any of the diseases which stand in an etiological relation to cardiac diseases. Her urine was normal. Careful auscultation discovered no valvular lesions. All the valvular sounds were clearly audible, but weak. The diagnosis made was weak heart from malnutrition, the latter being due to some unknown cause. She was slightly jaundiced, her skin being very much like parchment. She grew gradually weaker and progressively emaciated, the coldness of the extremities reaching up to the elbows and knees. To the touch she was more like a cold-blooded animal than the genus homo. Her urine was repeatedly examined and was always normal. She entered the Maryland General Hospital in the fall of 1887 and died about three months later. The autopsy was held by the late Dr. E. R. Walker. The heart and lungs were removed, the latter being sound and free from adhesions to the pleuræ or pericardium. The valves of the heart were perfectly sound, but the walls of the heart were atrophied and thin and on close examination there was found a uniformly adherent pericardium which could be peeled off. The whole organ was firmly compressed by the adherent sac. All other organs were normal except the liver, which on close examination was found to contain small points of scar tissue here and there, the sites of former localized hepatitis, no doubt. The coronary artery had doubtless been compressed by the adherent sac and thus the nutrition of the heart had suffered.

CASE II.—Widower, aged 42, salesman in clothing house. Admitted to the Maryland General Hospital, November 10, 1891. His health had been good till three weeks previous, when he had considerable pain about the precordia. Said he had no fever at any time. Temperature was always normal while he was in the hospital. Urine normal. He had never had rheumatism nor any disease to which pericarditis could be referred. No apex-beat discovered by inspection or palpation. No friction fremitus on palpation. On percussion, an increased area of dullness over lower cardiac region. Auscultation revealed the to-and-fro new-leather sound, heard with increasing loudness as the ear approached the base from the apex. A rather loud aortic regurgitant murmur was heard in the

second right intercostal space, the blowing character of which was in sharp contrast to the pericardial friction sound. I pronounced it a case of pericarditis with effusion, complicated with endocarditis and aortic valvular lesions. Dr. Streett, who also examined the patient, came independently to the same diagnosis. The patient, a few days after coming under my care, disobeyed certain rules of the hospital and was dismissed, much to my regret.

Dr. W. T. Howard, Jr., thought that the lesions described in the liver in the first case were suggestive of syphilis. If this case could be associated with syphilis it would be most interesting, as syphilis has never been set down as a cause of pericarditis.

Dr. Merrick: I could not exclude syphilis. There were no symptoms of syphilis as long as the case was under my care. The lesions were on the surface of the liver and dipping down a quarter of an inch or so. Dr. Walker, who made the autopsy, thought they were the sites of hepatitis.

Dr. Howard, Jr., related a number of cases of adherent pericarditis which had come under his observation.

Dr. A. K. Bond: I have no doubt at all that Dr. Merrick's cases were cases of idiopathic pericarditis. One cause of pericarditis and endocarditis that might sometimes be mistaken for idiopathic, is rheumatism, where there is no associated joint pain. In a case under my observation this winter, I found signs of an old pericarditis. The patient told me that these signs had been present since childhood. She said she had never had rheumatism. As in infancy and childhood rheumatism sometimes manifests itself not in joint pains, but by other symptoms, such as chorea, I asked the patient if she had ever had St. Vitus' dance. She replied that she had had several very obstinate attacks.

Dr. Charles O'Donovan quoted from Ziemssen, Loomis, Gowers and others to show the extreme infrequency of idiopathic pericarditis. In Dr. Merrick's first case a very considerable lot of trouble was found in and about the liver, and it seems hardly proper to record this as a case of acute idiopathic pericarditis. The second case was not the subject of autopsy and is, therefore, incomplete. It is quite possible that some cause may have existed which was not detected. It is plain in my mind that the first case was not one of idiopathic pericarditis.

Dr. J. F. Martenet: In ten years' special work in chest trouble, I have never come in contact with a case of idiopathic pericarditis. I should think that the first case of Dr. Merrick's was of syphilitic origin. I do not know that Dr. Merrick has eliminated chorea. We scarcely ever have a case of chorea persistent in character, in which we do not have some trouble in the heart area. Dr. Osler says that one should look for troubles in the cardiac region, associated with and following chorea. It seems to me that there must be some other affection, possibly early in life, that he has not traced out.

Dr. Howard, Jr., thought it extremely improbable that a case of idiopathic pericarditis ever occurs. The second case, in which there was no autopsy, he thought must be excluded.

Dr. J. W. Chambers: It seems to me that the interest in Dr. Merrick's case is not so much the *cause* of pericarditis, but the fact that this woman died and the principal lesion was in the pericardium. Lesions of the heart, endocardium, pleuræ, kidneys and other organs, which are usually associated with pericarditis, were absent. "Idiopathic" is simply a waste-basket in which we throw things for convenience. Undoubtedly this trouble had a cause, but what the doctor means to say is that he could not find out the definite cause.

Dr. O'Donovan: I think Dr. Chambers' remarks are hardly *apropos*. The

whole world is searching for a case of idiopathic peritonitis and as far as I know they have not been able to find it. The same holds good as to pericarditis. It is hardly the thing to claim these cases as almost isolated cases of a very rare disease. Every case should be judged on its merits.

Dr. Chambers: Since the whole world is looking for a thing and has not found it, it shows that it is not particularly interesting to the general practitioner. The point of interest I still think is that in that particular case the only lesion was an inflammation of the pericardium.

Dr. O'Donovan: There was liver trouble.

Dr. Chambers: The marked lesion was in the pericardium.

Dr. Norment: With Dr. Chambers and Dr. O'Donovan, I doubt if there is idiopathic anything, if by "idiopathic" is meant a disease without an underlying cause. The question of associating a previous illness with the case in hand is an interesting one. Dr. Howard knew of no case in which syphilis has been recorded as a cause of pericarditis. If syphilis was likely to be a cause of pericarditis, in the present case, it would have been the cause of it in many other cases as well, considering the prevalence of syphilis. If a man had syphilis twenty years ago, pneumonia ten years ago, typhoid or what-not five years ago, and there is not a chain connecting these diseases with the disease that takes him off, it seems hardly fair to attribute lesions that are present to-day to something that happened long since. When we cannot say what is the matter, it is better to say that we do not know; and it is in this sense that the word, idiopathic, is used to-day rather than in a definite sense.

Dr. Merrick: With regard to syphilis, in searching over the authorities, I could not find syphilis as ever having been the cause of pericarditis. As to rheumatism in childhood, that is readily disposed of by the character of the adhesions, which showed the trouble to be of recent date. I grant what the gentlemen have said of the extreme rarity and perhaps the impossibility of idiopathic pericarditis. All of Dr. O'Donovan's authorities acknowledge that such a thing may occur. DaCosta says there are cases in which the closest investigation has failed to show any assignable cause. In twenty years' practice, during 12 or 15 of which I have had all the clinical material of the North-western Dispensary, averaging four to six thousand cases in a year, I have had an opportunity of getting hold of such a case if such a thing exists. Dr. Walker, who had made over 3,000 post-mortems, particularly noted this case in the hospital, and that was the reason an autopsy was held. The case was a unique one in Dr. Walker's experience.

1519 N. Broadway. W. T. Watson, M. D., Secretary.

DIURETIN IN CHILDREN.

According to Demme this drug can be given to children between two and five years of age in doses of 0.50 gramme daily, and in doses of 1.50 grammes to those between six and ten. In infants under one year it is liable to cause gastro-intestinal irritation. It has proved of service in the dropsy of scarlatinal nephritis as well as in that due to mitral disease, after digitalis had proved ineffectual. Its action is not cumulative, but in one case of amyloid degeneration of the liver, kidneys, and spleen, its use caused an erythematous rash, accompanied with profuse diarrhœa.—*Lancet.*

Dr. W. F. Waugh recommends use of glycerine in hypertrophied tonsils. The glycerine must be applied very frequently.

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BALTIMORE, MAY 21, 1892.

Editorial.

JOURNAL CLUBS.

An interesting reprint of articles upon "The Seminary Method in Asylum and Hospital work," by Edward Cowles, M. D., of Massachusetts, and upon "Journal Clubs," by Henry M. Hurd, M. D., Superintendent of the Johns Hopkins Hospital, has set us a-thinking upon this subject.

It is evident that co-operation is necessary now-a-days, if the busy physician would keep up with all the medical facts and theories that are brought out in our journals. We are frequently asked by young practitioners "which is the best journal to subscribe to;" and, in spite of our high appreciation of our own JOURNAL, we are compelled to say that no one journal can cover all the ground of periodical medical literature. Next to the subscription to the local journal which represents the physician's own State, the best thing is undoubtedly a club for weekly or bi-weekly review of the whole list of leading journals. The drift of the age is toward the formation of local medical societies. The formation of great representative societies of practitioners in Baltimore has already reached its fullest development. The machinery is all in order, and it remains only for the members of each society to raise the standard of their literary work. The next development may be expected in the line of local clubs, inferior in size to, and less formal, perhaps, in character than those already formed; yet not confined to specialists interested in only one department of surgery or medicine.

The literary activity and attractions of life at the Johns Hopkins Hospital is largely due to its local clubs for journal work and clinical reports, which have enlisted the interest and co-operation of many city doctors.

A very excellent society of younger general practitioners, calling itself the "Journal Club," has been in existence in the city for some time; although it has modestly refrained from publication of its papers and discussions.

It remains for our other hospitals, and for neighborhood circles of general

practitioners in the city and country, to consider whether they might not gain great intellectual stimulus and improve their methods of practice by the formation of journal clubs. The three foes of medical progress, "rust," "ruts," and "jealousies," would all be combatted by such gatherings.

As to the conduct of journal clubs, several methods are suggested by Dr. Hurd. The number of journals within reach may be divided among the members, each reporting on matters of interest to him; or, each member may take a subject or a group of subjects and report upon it; or, the president (chairman), who should be chosen for his special fitness for the work, may assign subjects to each member. The performance of assigned duties must be made positively obligatory; and each member must be compelled to do his share of work. Accurate records of proceedings, papers and discussions should be preserved.

CARLSBAD.

Two articles just received by us from our friend Dr. London, the veteran physician of Carlsbad, suggest a few words in regard to this famous health resort of the Austrian Empire. We may all acquaint ourselves with the physical properties of the bottled waters and dried salts of its mineral springs, which are sold by druggists, and we have probably tested their virtues in our practice.

The town of Carlsbad is situated in the north-western part of Bohemia, in a mountainous region. For hundreds of years its waters have been famous for their healing virtues. At first they were used in the form of baths; in a succeeding period they were drunk in excessive quantities; in recent times they have been used in both ways by multitudes of visitors, but only under the direction of resident physicians; careful dietetic measures being instituted during the course.

Numerous analyses show that the waters are of an alkaline saline character. The waters of the different springs differ in ingredients and in temperature, the Sprudel waters having a temperature of 162° F.; and likewise in the amount of free carbonic acid gas present. Carbonate of sodium, sulphate of sodium and chloride of sodium are the important saline ingredients.

The therapeutic indications for the use of the waters seem to be based on simple principles. The waters exert, first of all, a local influence on the stomach and intestines, cleansing these parts from unwholesome contents and excess of mucus. If taken cold, the waters exert a more decided purgative influence than when taken hot.

The final action of the waters is through the absorption and subsequent excretion of their ingredients, whereby the tissues and fluids of the whole body must be affected, certainly the urine, and in consequence the surfaces with which the urine comes into contact. In particular, the waters are indicated in dyspepsia, ulcers and chronic catarrh of the stomach; constipation, ulcers and chronic catarrh of the intestines, and hæmorrhoids; chronic hyperæmia and enlargement of the spleen (as after malarial fevers); hyperæmia and hypertrophy of the liver,

simple jaundice, and gall-stones; chronic catarrh and calculi of kidney and urinary organs; chronic hyperæmia and enlargement of prostate; chronic catarrh of womb; gout; corpulence; *diabetes mellitus*; and the various results of abdominal plethora.

The waters are contra-indicated in nervous diseases; suppurative states; tuberculosis; cancer; ulcerative syphilis; diseases of the heart and arteries; anæmia; hæmorrhagic diathesis; senile atrophy and cachexia; cirrhosis of liver with dropsy; pregnancy; some forms of Bright's disease; and malignant diabetes.

Dr. London reports in one of his papers a recovery from perforating ulcer of the stomach with severe hæmorrhages; in the other the cure of a very persistent chronic dysentery, by the use of the waters.

We may state, for the comfort of patients who think of going to Carlsbad, that it has a good corps of physicians, many of whom, including Dr. London, speak and write English very well.

The post of Assistant Resident Physician at the City Insane Asylum, Bayview, is now vacant. Applicants for the position will address, in writing, Dr. H. J. Berkley, 1303 Park Avenue, Baltimore.

Reviews, Books and Pamphlets.

Transactions of the American Orthopedic Association. Fifth Session, held at Washington, D. C., September, 1891. Vol. 4. Philadelphia: published by the Association, 1891. 8vo. Pp. 400.

This excellent volume should be perused by every practitioner interested in surgery. The group of articles and discussions, by most eminent orthopedic workers, concerning the treatment of abscesses resulting from disease of the spine, is especially interesting. Short contributions on "the joint stiffness following gonorrhœal rheumatism;" on "syphilitic spondylitis in children;" on Pott's disease in the old;" and on "wiring the spinous processes in Pott's disease" (as yet untried); are particularly worthy of attention.

The Science and Art of Midwifery. By Wm. Thompson Lusk, A. M., M. D., Professor of Obstetrics and the Diseases of Women and Children in the Bellevue Hospital Medical College, etc. New edition, revised and enlarged, with numerous illustrations. New York, D. Appleton & Co., 1892. 8vo. Pp. 760. Price $5 00.

This well-known text-book and book of reference needs no endorsement from us. It is generally admitted to be one of the very best in the English language. The present edition (the 4th) has been carefully revised so that it is presented by the author as "essentially a new book," and fully up to date.

Medical Progress.

SOME OF THE RARER COMPLICATIONS OF RHEUMATOID ARTHRITIS.

Dr. Spender, of Bath, Eng., contributes an interesting article on this subject to the *Brit. Med. Jour.*, April 30, 1892. Commenting upon the rarer complica-

tions of this obscure disease, he remarks: 1. The circulation is disturbed in such a way as to suggest that the excitability of the heart is no longer controlled by vagus action. (He cites two cases in which the pulse was permanently at 132 and 140.)

2. There are two extreme forms of pigmentation. *a*, The melasma is so like suprarenal discoloration that the first glance of a patient so disfigured reminds one of Addison's disease. Wrinkles on the forehead are white furrows parallel with so many dark ridges; and the skin of the neck looks as if soaked through with walnut dye. It is analogous to the thyroidal bronzing described by Dr. Drummond. *b*, The multiple xanthoma of far advanced rheumatoid arthritis is decidedly rare. I have already published some account of a lady of middle age (under my care from 1884 to 1886) who had yellow patches and rashes on a large part of her body. The exceptional point in her case was the separation and twisting of most of the nails of fingers and toes from the matrix by an accumulation of dry, chalky material. But circlets of a bright yellow tinge are not uncommon around the finger joints on their dorsal surface. *c*, A curious complication is the coming and going of small areas like bruises on a rheumatoidal limb. They pass through the same sequence of colors as a bruise. So exactly is the "bruised" area like the result of an ordinary contusion, that no other comparison would suggest itself to any one who saw it for the first time. In an elderly lady sent to me by Dr. Lewis, of Folkestone, and in a lady of middle age sent by Dr. Gray, of Oxford, the rather sudden development of these chromatic patches determined the nature of each case beyond dispute. They come without warning and even without the patient's knowledge. They are mostly of about the diameter of a florin, not raised, and they can be pressed without eliciting any sensation like pain. The tracks of nerves or of blood vessels cannot be associated with them. In my last example of this strange phenomenon the discoloration was purple black at its height, and then gradually subsided through a procession of hues to a light dingy brown.

3. The common atrophy of muscle and skin which goes along with rheumatoid arthritis has been described by many writers, notably by Dr. Ord and Dr. Archibald Garrod; and it is my business here to describe only those errant phases of motor function which are eccentric and rare. A "to-and-fro spasm" of one arm, of the strict shaking palsy kind, has been observed by me in two cases in which the rheumatoidal lesion was confined very much (though not entirely) to the shaking limb. An extremely cold, damp hand, purple blue in tint, and with the distinctive feature of glossy skin, may display a curious mimicry of athetotic movement so far that the fingers do not bend or extend in harmonious and coherent way. And I have seen the fingers engaged in slow, involuntary movements when the attention has been directed elsewhere.

4. The neuralgia which is such a frequent companion of rheumatoid arthritis deserves special note, because it is so commonly misunderstood. As an early symptom its value is scarcely recognized yet. Take an actual instance: A lady in middle life has for a period of six weeks an acute pain in the region of the right shoulder. It is always there—often it is worse at night; but for a while there is no paresis of muscle or impediment to free motion of the shoulder joint. The cause of the pain is obscure; no medical advice is sought, and nothing definite is done. Gradually the arm cannot be lifted: even passive movement cannot raise it beyond a certain angle. Before skilled care is bestowed upon the case the first stage of rheumatoidal change has come and gone; alteration in the synovial secretion and some adhesion between the joint ends of

the bones are accomplished facts; and there is distinct atrophy of muscle around the shoulder and upper arm. A mere surface study of this brief history might suggest that "rheumatism" of the shoulder was the sole cause of the pain; that it was, in short, a rheumatic pain pure and simple. I believe that the sequence of events was precisely the other way, and this is my reading of them. Something wrong began in the lateral sensory column of the spinal cord; a dynamic irritation was set up in the cervical plexus, as expressed by the pain, and this perversion of the muscular energy resulted, after a time, in actual morbid change.

This phenomenon of pain marks an intimate kinship between rheumatoid arthritis and locomotor ataxy. I have mislaid the reference to a case published in a medical journal within the last few years, the record of which stated that an injury to the nerves of the upper arm was followed by an arthritis of the elbow which closely mimicked a rheumatoidal lesion.

Am I straining analogies and alliances too far in thinking that there may be a suitable link between rheumatoid arthritis and osteitis deformans? A rheumatoidal lady now under my care has her right collar bone big and misshapen. The external or flat segment is as much distinguishable from the internal or curved segment as if there had been a fracture, and the separated fragments of bone had united in an irregular and clumsy way.

5. Vasomotor derangements of an extreme type are exhibited now and then in the hands and feet. Dampness and wetness are common enough; but it is not very infrequent for the hands to stream with perspiration as if just immersed in water. The long trough in the situation of the vertebræ may be a canal of running moisture. No symptom is more unerringly diagnostic than this. A fresh patient is admitted into our Mineral Water Hospital, and we are for a moment in doubt about the nature of the arthritis. If the hands do not tell the tale plainly, we turn up the bedclothes and see the dew on the feet, and the problem is solved beyond debate; and a purple blue hand, frigid on even a hot summer's day, may show a mottled finger so dark in tint as to remind one of the vagaries of Raynaud's disease.

A NEW MUSICAL INSTRUMENT.

In the *N. Y. Med. Jour.*, May 14, 1892, the following odd case is described.

The patient was reared on the shores of the Mediterranean, and it was here that he first noticed his remarkable power. While bathing one day he observed upon strong inspiration the sensation of cold in his pelvis and abdomen, and at the same time felt the sea water entering his rectum. In a short time he was compelled to empty his bowel, and noticed that he had taken in a much larger quantity than he had supposed. By practice in the ordinary bath and in the sea, he became able to store a considerable quantity of water, to retain it for some time, and to eject it with much greater force than at first. Later on he noticed that he could accumulate air in his bowels, as well as water, and by its expulsion could give rise to certain variations of sound. Applauded by his associates, who acknowledged his superiority in this class of exercise, he eventually developed the faculty beyond measure, and frequently gave exhibitions of his art before a select circle of his friends. From these reunions he began to exhibit his powers in the clubs and cafés until he became the best known and greatest curiosity of the place. As his reputation spread he made journeys to the surrounding towns and villages, Bezin, Nimes, Toulouse, and Bordeaux. At the latter place he was examined by many of the medical faculty, and a discussion of the case was reported in the *Gazette*

hebdomadaire des sciences médicales de Bordeaux for March, 1892, in which Dr. Ferron and Dr. Boursier said they had each seen men possessing the power of storing and expelling considerable quantities of water from the rectum, but had never seen one able to draw in and expel air. In addition to this power, however, this individual has a peculiar control over the external sphincter, by which he is able not only to control the escape of air but also to imitate the sounds of a violin, a trombone, and other instruments, and to reproduce melodies thereby which may be distinctly recognized. To do this he stands with his legs straight, his body flexed upon his thighs, and his head bent first to one side and then to the other. During the performance he moves his buttocks in all directions, seeming thus in some way to be able to govern the conformation of the anus and to produce the different sounds and tones. There is said to be no disagreeable odor to the expelled air, as he clears the ground well before beginning operations. The process consists of two acts, inspiration and expiration, the former taking only one or two seconds, and the latter being capable of being prolonged from ten to fifteen seconds. These facts have been verified by Professor Richet and Professor Poirier, who have made a prolonged study of the case, as well as by many others of the faculty of Paris. From a physiological point of view the case is very interesting, opening up the field for discussion and study as to how far the colon can be made to supplant or supplement the lung in voluntary respiration, and the sphincter of the anus to take the place of the lips in playing on wind instruments.

THE UTERINE CATARRHS OF YOUNG GIRLS.

From a sensible article on "the examination of young girls," in the *Med. and Surg. Reporter*, May 14, 1892, by Dr. H. C. Coe, of New York, we clip a few paragraphs. Speaking of electricity and other agents which may bring about a cure without the very disagreeable necessity of a local examination, he says:

In applying the galvanic current, then, you will practically come to give more heed to the sensations of the patient and the after-effects of the application than to the exact dosage. The class of cases under consideration are much relieved by placing one electrode over the sacrum and the other over the ovarian region, passing a current of moderate intensity, just sufficiently strong to cause a warm, burning sensation. This simple treatment repeated twice or three times a week often produces a remarkably beneficial effect. I am unable to say just how the effect is brought about. There have been a good many learned explanations of the action of electricity on the pelvic organs, but they are like many other theories in medicine. We know simply, as a matter of fact, electricity does remove pain in those cases in which there is no serious organic change. Dysmenorrhœa is often entirely relieved. But you must tell the patient in advance that it will be necessary to give it a fair trial, and not to expect marvelous results from one or two applications.

I find that general practitioners often fail to recognize clearly the indications for the use of the different currents, made clear to your mind if you remember that the galvanic current is in general sedative, the faradic stimulating. If you want sedation (as in ovarian pain), apply the galvanic current. If there is non-development, amenorrhœa, a small infantile uterus or subinvolution you want stimulation, which is obtained by the frequently repeated shocks of the faradic current. In such a case put one pole over the sacrum and the other on the abdomen over the fundus uteri. If you make intra-vaginal applications, place one electrode against (or within) the cervix, the other on the abdomen over the fundus.

Regarding general treatment, iron is usually indicated, and I often use manganese. There is a preparation called the pepto-manganate of iron which acts well. I regulate the bowels with a mild laxative, usually cascara. The patients should bathe regularly. They may take a cold sprinkle, followed by a good rubbing. Regarding vaginal douches, I would refrain from using them as long as possible in the case of young girls.

THE COUCH.

There is an appeal in the following extract, originating with the *Med. and Surg. Reporter*, that gives it a right to go the rounds of the medical journals:

A room without a couch of some sort is only half furnished. Life is full of ups and downs, and all that saves the sanity of the mentally jaded and physically exhausted fortune fighter is the periodical good cry, and the momentary loss of consciousness on the up-stairs lounge, or the old sofa in the sitting-room. There are times when so many of the things that distract us could be straightened out, and the way made clear, if one only had a long, comfortable couch on whose soft bosom he could throw himself, boots and brains, stretch his weary frame, unmindful of tidies and tapestry, close his tired eyes, relax the tension of his muscles, and give his harassed mind a chance. Ten minutes of this soothing narcotic, when the head throbs, the soul yearns for endless, dreamless, eternal rest, would make the vision clear, the nerves steady, the heart light, and the star of hope shine again.

There isn't a doubt but the longing to die is often mistaken for the need of a nap. Business men and working women need regular and systematic doses of dozing, and next to a mossy bank in the shade of an old oak, which succeeding Junes have converted into a tenement of song birds, there is nothing that can approach a big sofa, or a low, long couch placed in a corner where tired nature can turn her face to the wall and sleep and doze away the gloom.

RUPTURE OF THE UTERUS CAUSED BY DIVULSION.

Dr. F. H. Murdoch, of Pittsburg, reports (*Med. Rec.*, May 14, 1892), the following case:

Two years ago a patient came to me with the following history: Mrs. A—, aged thirty-five, married, never had been pregnant, appetite poor, had painful diarrhœa most of the time, and suffered intense pain for a few days previous to and during menstruation. Examination showed so much constriction at inner os that the smallest sized probe would pass only immediately after the cessation of the menstrual flow. The depth of the uterus was two and one-half inches. Rapid dilatation was done under ether to the extent of an inch, twenty minutes being occupied in the operation. Result—First, menstrual period painless; second, slight pain; and third, pain quite severe. I decided to dilate again, more rapidly, and use a stem. The patient was anæsthesized. Goodell's dilator was introduced, and at the end of five minutes the dilatation was carried to the extent of ¾ of an inch. At this point the patient began to breathe through the uterus, the air entering and leaving the peritoneal cavity making a distinct blowing sound. Rupture of the fundus of the uterus at once suggested itself. I withdrew the dilator, and with care and gentleness introduced a sound into the uterus, allowing it to enter five inches, thus confirming the diagnosis of rupture. At this time the patient's pulse was ninety, and jerky, and her face was bathed in cold perspiration. The treatment consisted in swabbing the cervical canal with tincture of iodine, dusting the cervix with iodoform, and introducing a strip of iodoform gauze into the uterus for drainage, holding it in position by means of a vaginal tampon of boroglyceride. She was given a hypodermic of morphia and put to bed.

Her bowels were kept open once a day with Rochelle salts, turpentine stupes were applied to the abdomen, and six minims of Magendie's solution of morphia were given twice a day hypodermically to relieve pain. The tampon and iodoform gauze were removed on the second day. There was very little distention of the abdomen at any time, and only slight tenderness. The pulse never rose above 100 nor the temperature above 100½° F.; in fact, she made an uninterrupted recovery. Her menstrual periods since the last dilatation have been comparatively painless, she has gained flesh, her diarrhœa has ceased to trouble her, and she considers herself well. She has not become pregnant.

Medical Items.

Dr. W. T. Lusk has been elected an Honorary Fellow of the Obstetrical Society of London.

One-seventh of the adult deaths in London depend, directly or indirectly, upon alcoholic excess.

The University Medical College of New York City graduated a class of one hundred and sixty-two at its recent annual commencement.

Dr. S. C. Chew will read a paper on "The Different Forms of Cardiac Pain" at the meeting of the Association of American Physicians, to be held May 24th to 26th.

Dr. James M. Craighill has been elected to fill the vacancy of corresponding secretary to the Medical and Chirurgical Faculty, caused by the resignation of Dr. Jos. T. Smith.

The second annual meeting of the American Electro-therapeutic Association will be held in New York, October 4, 5 and 6, 1892, at the N. Y. Academy of Medicine, 17 W. 43rd Street. W. J. Morton, M. D., President; H. R. Bigelow, M. D., Secretary.

At the recent International Congress of the Red Cross Society a resolution was adopted petitioning the Signatory Powers of the Geneva Convention to unite in extending the benefits of the said convention to maritime warfare, under appropriate conditions.

Manchester, England, has a Healthy Homes Society, the purpose of which is to instruct the working classes (especially the factory and mill hands), in the sanitary improvement of their houses and of their mode of life. It has existed two years, and has been quite successful, the attendance on its meetings and instructive lectures steadily increasing.

LOST.—During the recent meeting of the Medical and Chirurgical Faculty, at the corner of St. Paul and Saratoga Streets, a natural-wood handle umbrella was left in the office of the Nurses' Directory. If the person who took it from there by mistake will kindly return it to the gentleman in charge, or leave it at the office of the JOURNAL PUBLISHING CO., 209 Park Ave., the owner will be much indebted.

Dr. Wilmer Brinton and bride sailed on Wednesday last from this port on the steamer Weimar, of the North German Lloyd Steamship Line, for an extended trip through Europe. They will in all probability not return until October 1st, during which time they will visit Bremen, Berlin, Vienna, Munich, Wittenberg,

Paris and other points of interest "on the other side." The many friends of the happy pair wish them a safe and joyful trip.

The Association of American Medical Colleges will hold its third annual session in the Detroit College of Medicine, Wednesday, June 8, 1892. Dr. N. S. Davis, President of the Association, will read a paper entitled, "To What Extent Should Clinical Instruction be Afforded the Student of Medicine in Regular Course?" Dr. V. C. Vaughan, of the University of Michigan, will read a paper entitled, "To What Extent Should Laboratory Instruction be Afforded the Student of Medicine in the Regular Course?"

The Berlin Society of Homœopathic Doctors, in conjunction with several other homœopathic societies here, recently petitioned the magistrates of Berlin to establish a special homœopathic hospital, or at least to set apart a ward in one of the city hospitals for patients who wish to be treated homœopathically. The magistrates have resolved to reject this request, on the ground that it is not expedient to establish a special hospital for the adherents of a special therapeutic system deviating from that of modern medical science.

The American Surgical Association passed the following resolution at its last meeting: *Resolved*, That the President be empowered to appoint a committee with authority to confer with the friends and admirers of the late Professor S. D. Gross, and with the *profession at large*, for initiation of a movement on the part of the Association, having for its object the erection of a monument to Dr. Gross, in Washington, D. C. Dr. L. McLane Tiffany represents the State of Maryland on the Committee. The monument will cost about $12,000, $3,500 of which is already assured.

The following named distinguished gentlemen have been delegated to represent the British Gynæcological Society at the International Congress of Gynæcology and Obstetrics, next September, at Brussels, Belgium. Drs. Robert Barnes, A. S. Simpson, Granville Bantock, Lawson Tait. Great preparations are being made to entertain visiting physicians. His Majesty, King Leopold, will assist at the opening of the Congress. There will be a grand reception by the Belgian Gynæcological Society; gala performance at the Grand Opera, also a banquet by the Belgian Gynæcological Society; garden party in the garden of the royal family, etc. For all information relating to the Congress, address, Dr. F. Henrotin, 353 Lasalle Ave., Chicago, Ill.

The following are the hotels and their rates for delegates to the meeting of the American Medical Association at Detroit: Russell House, $3 per day and upward; Hotel Cadillac, $3 per day and upward; Hotel Normandie, $2 and $2.50 per day; Wayne Hotel, $2 and $3.50 per day; Griswold House, $2 per day; Hotel Tacoma, $1.50 per day; Griffin House, $2 per day; Case Avenue Hotel, $1.50 per day; Hotel Renand, $1.50 per day; Queen Elizabeth Hotel, $1.50 per day; Rice's Hotel, $1.25 per day; Hotel Goodman, $1 per day. The local Committee on Hotels, etc., will also be glad to furnish members with the addresses of good boarding houses. For any further information address W. G. Henry, M. D., Chairman Committee on Hotels, etc., 68 Lafayette Avenue, Detroit, Mich.

WANTED.—Young physicians or medical students to canvass the cities of Baltimore and Washington and the States of Maryland, Virginia, West Virginia, and North Carolina, for a medical publication. To good man a rare chance of making money offered. Apply at this office, 205 Park Ave., in person or by letter.

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CONTENTS

ORIGINAL ARTICLES.

Post-Febrile Insanity. By Henry M. Hurd, M.D., of Baltimore. 661

Diet and Exercise in the Treatment of Epilepsy. By Samuel J. Fort, M. D., Ellicott City, Md. . 667

EDITORIAL.

The Protective Influence of Fads. . . 674

The Joint-Stiffness which Follows Gonorrhœal Rheumatism. 675

Pott's Disease and Pregnancy. . . . 675

SPECIAL ABSTRACTS.

Hydrochloric Acid in the Treatment of Vomiting.—Bacillus of Measles.—Palliative Treatment of Cancer of Uterus.—Treatment of Cancer.—Treatment of Pyogenic Affections by Production of Artificial Abscesses. . . 676

MEDICAL PROGRESS.

The Causes of Jaundice.—Neurotic Constipation. A Case of General Fatty Deposit.—Cysts of the Tonsils. 677

MEDICAL ITEMS. 681

Original Articles.

POST-FEBRILE INSANITY.*

BY HENRY M. HURD, M. D., OF BALTIMORE.

Superintendent of the Johns Hopkins Hospital.

In view of the fact that within the past five years the subject of post-febrile insanity has excited renewed attention and elicited discussion, I have deemed it proper to present the salient aspects of this form of disease in lieu of a report covering a wider range of psychological medicine.

The topic is not a new one. Chomel,[1] 1834, spoke of it as a derangement of the mental faculties which might take the form of mania and disappear with convalescence, or might assume a severe type with an uncertain result. Esquirol,[2] 1839, thought that fevers of a low character left after them a chronic delirium which ought not to be confounded with mental alienation, but which, from his description, could really have been nothing else. Simon,[3] 1844. reported several cases of insanity following typhoid fever, and considered that insanity was developed during the first days of convalescence and was probably a continuation of the delirium. Sauvet,[4] 1845, gave many illustrative cases which he analyzed carefully and described very clearly. Thore,[5] 1846, also observed and reported at length a number of cases. Baillarger, in 1865, thought that fevers produced insanity in two ways: by their effect upon the nervous system, and by the anæmia which they caused. Clouston,[6] 1883, regarded post-febrile insanity as due to an exhaustion of vital powers caused by zymotic diseases analogous to the nervous affections of childhood. Wood,[7] 1889, "believed that although insanity

*Read before the Medical and Chirurgical Faculty of Maryland, April 28, 1892.

following acute disease varies greatly in its symptomatology, in almost all cases there is one common fundamental brain condition, and this fundamental brain condition bears no specific relation to the disease which has produced it, but may be the outcome of an altered nutrition which is produced by an exanthematous disease like typhoid fever, or by a diathetic disorder like rheumatism, by an accidental traumatism or by a surgical operation," and he thought "there are etiological and symptomatological reasons for believing that insanities after acute disease are identical in their nature." He argued further that if the insanity has a specific relation to the poison of the disease there must be half a dozen specific insanities connected with acute diseases—a supposition which he regards untenable. Hence, he proposed the term "confusional insanity" to cover the whole group of mental diseases which he regarded as due wholly to the exhaustion of the nervous system from shock or wasting disease. Korsakoff,[8] on the other hand, regarded a similar condition as due to a poison, acting in some cases upon the peripheral nervous system, and in others upon both peripheral and central nervous systems.

However desirable it may seem to simplify the etiology and symptomatology of this group of diseases by thus ascribing them to a single cause, and to class the manifestations together as "confusional insanity," it seems illogical to do so for sake of convenience merely, if thereby conditions are blended which are not identical and causes are mingled which are distinct. Hence, I shall not hesitate to consider these cases as of a three-fold character, viz.: 1. Those developing from shock. 2. Those developing from specific poisons. 3. Those developing in consequence of anæmia and nervous exhaustion.

1. *Insanity Developing from Shock.*—Under this head we have cases of confusional insanity which are due to surgical operations, childbirth, the puerperal condition, etc. Here we have a history of great mental strain or anxiety, sleeplessness, delirium, hallucinations of hearing or sight, delusions of apprehension, and often great mental disturbance. The insanity develops suddenly as a rule and runs a rapid course, generally terminating in recovery, but sometimes in death or chronic insanity. In my experience, the symptoms are usually more active in these cases and there is an absence of fixed delusions.

2. *Insanity Developing from Specific Poisons.*—Under this head are comprised the delirium of fevers, both intermittent and exanthematous, of pneumonia, of uræmic poisoning, the transient insanity of influenza, the mental confusion of multiple neuritis, the delirium of iodoform, salicylic acid and chronic alcoholic poisoning and the delirium of puerperal fever. In this group of cases we have a poison acting directly upon the central or peripheral nervous system, producing an intoxication, as shown by confusion of ideas, incoherence and a more or less rapid flow of thought. This poison may be of the nature of uræmia or of some of the toxic albumens—which Welch has shown to be produced in pneumonia and diphtheria, which possess a special toxicity to the nervous system—or an intoxicating drug which has a prolonged action. These poisons produce an active delirium which is generally self-limited and disappears when the exciting cause is removed and the period of convalescence is established. This condition should not be confounded with the next condition.

3. *Insanity Developing from Anæmia and Nervous Exhaustion.*—Under this head we have an insanity which arises secondary to the fever and is to be regarded as the expression of an exhausted physical state. Here we have delusions of fear and apprehension, hallucinations of sight and hearing, perversions of taste, of cutaneous sensibility, and frequently progressive stupidity and mental impair-

ment. I would not be understood to assert that the delirium which is developed during the active stage of typhoid fever may not give rise to impressions which are retained in the subsequent stage of the disease when post-febrile insanity develops. I believe such to be the case many times, especially in those patients where a hereditary tendency exists to mental disease, or where there have been relapses or a tedious convalescence. The exact predisposing causes of the original delirium are not clearly known. In some excitable organizations, the quickening of the brain circulation, which results from any fever, produces an immediate delirium. This is true of children and those who retain a brain excitability analogous to that of childhood. It is peculiarly evident in some persons suffering from intermittent fever, who invariably have a delirium during the hot stage. In these impressible organizations, it is not strange that delirious conceptions, formed during the fever, should impress themselves vividly upon the brain and give rise to fixed delusions in the latter stages of the disease. It is not difficult, however, to perceive that in post-febrile insanity a new condition is present which has been grafted upon the original delirium, and which, while it may be moulded into the form which the delirum has made ready for it, is essentially a new condition. I think I can render my meaning clearer by briefly citing cases illustrative of the three conditions above referred to.

Case I.—*Maniacal Excitement following Removal of Diseased Ovaries.—Incoherence lasting several months.—Ultimate Recovery.*

E. A., female, farmer's daughter, age 28, was operated upon at the Johns Hopkins Hospital for the removal of two diseased ovaries. The operation was rapid and uncomplicated, and she made an excellent recovery. The sutures were removed upon the eighth day and the wound was found to have healed perfectly throughout. She displayed at this time irritability, but no other symptom of mental disease. On the tenth day she became loquacious and spoke of her remarkable recovery and of her freedom from pain, and was manifestly elated. Upon the sixteenth day, actual maniacal excitement developed. She laughed at trifles, talked foolishly, and was incoherent. Her excitement continued to increase until she became noisy at night, violent and destructive. She got no rest except under the influence of hypnotics. At the end of six weeks she was removed to an asylum for the insane, where her excitement continued for a number of months, but gradually subsided, and a complete recovery took place. The patient had always been nervous and excitable, but had never before shown any mental derangement.

Case II.—*Insanity Developing from Pneumonia with Systematized Delusions Originating in the Delirium of Fever.—Recovery.*

E. S. S., female, age 35, merchant's wife, had an attack of pneumonia in 1869, accompanied by a high grade of delirium. During her delirium she had hallucinations of both hearing and sight, and was much excited by the presence of her husband, and also of her nurse. When the pneumonia subsided, she was confused, suspicious, lacking in ability to fix her attention and with definite delusions about her husband. For a long time she was unable or unwilling to give utterance to them, but, finally, she detailed them at great length and with considerable fullness of detail. She believed that her husband during her illness had improper relations with the nurse in her presence. These ideas were retained for many months, and her feelings towards her husband became so bitter it was necessary to place her in an asylum for the insane. For a long time she continued confused, suspicious, and influenced by delusions, but at the end of a year her morbid sentiments disappeared and she became affectionate towards her husband, but easily confused and fatigued. She often referred to her delusions

as a horrid dream and fully realized their morbid character. Her convalescence was fully established in 1870, and since that time—a period of twenty-two years —she has been perfectly well.

CASE III.—*Melancholia Developing during Convalescence from Typhoid Fever.* The following case, reported by Dr. Thayer, of the Johns Hopkins Hospital, furnishes an excellent example of true post-febrile insanity. The patient, a male, age 29, with no history of hereditary tendency to insanity, but with a history of alcoholic excess, was admitted to the Johns Hopkins Hospital September 24th, 1891, with the statement that he had given up work three weeks before on account of headache, general pains and moderate diarrhœa. His appearance and history indicated that he was in the third week of typhoid fever. He was put upon liquid diet and given baths at a temperature of 70°F., every three hours, whenever his body temperature went above 102.5°. The temperature pursued a steadily downward course, only four baths being called for, and after September 28th became practically normal. On October 8th, the patient having had eggs before, had milk toast and soft solids added to his dietary and was allowed to sit up in bed. On the evening of October 10th, he appeared for the first time nervous and anxious about his condition. He asked if he were very ill and whether there was any chance of his recovery. His anxiety was made light of and when asked the origin of the ideas he said that one of the patients told him he was very ill. On the 11th, he was given, for the first time, meats, and was allowed dry toast with baked potatoes, but on this date he was more anxious about himself and seemed convinced that he was in a critical condition. On the 13th, his physical condition having steadily improved, the temperature having been normal for 15 days, and the diet having been increased to nearly normal proportions, he was allowed to sit up for a short time out of bed. On the same evening he was found to be in a very nervous condition. He was despondent, weeping, and, when the physician came by, seized his hand and begged him to save him. He declared that he had seen the head nurse read the order that he was to be cremated that evening, and had also seen her receive the announcement that the box in which the operation was to be performed had arrived and was stored in the room below. He could not be convinced of the absurdity of his ideas. On the following day I saw the patient and suggested that he should be kept in bed. The condition was not materially changed; he was tearful and very much alarmed about himself. He insisted that the head nurse had told him that he was to be cremated because he had acquired syphilis, which he denied, and his only request was always that he might be saved. On the following day he seemed rather better, and appeared a little ashamed of the ideas which he had had on the day before, but he soon went back into his former condition. From this time on until the 26th of October, when he was discharged from the Hospital with the hope that a change of surroundings would relieve his mental distress, he grew steadily worse. He became constantly silent and depressed and suffered much from delusions of fear and apprehension. Nothing has been heard from him since his discharge.

From these illustrative cases it is evident that we are not justified in attaching the title, "confusional insanity," to such cases as a whole. Cases of the first and second class, in which we have shock or a special poison acting upon the nervous centres, as might be expected, generally display mental confusion, incoherence, and even excitement. Patients of the third class, however, are much more apt to have systematized delusions of apprehension and melancholic symptoms. I have taken some pains to examine the histories of patients to ascertain the form of disease present in the reported cases of post-febrile insanity.

Out of 23 cases whose histories have been fully reported, 11 were of typhoid fever; in four of these insanity developed during the fever, generally in the form of delirium; and in seven, after the fever was over. In seven out of the 11, there were delusions of distrust and apprehension. In one there were delusions of grandeur; and in the remainder, marked mental enfeeblement. Eight recovered; two died; and one did not recover. Two were cases of pneumonia; in one of whom the disease developed during the attack, and in the other, subsequently. One had violent delirium; the other, delusions of apprehension; both recovered after a tedious illness. Nine of the 23 cases were surgical. In these, mental disturbances generally developed about the ninth day; although in one it was at the sixth, and in another at the twenty-first. In five cases there was depression, and in four excitement; four recovered; four died and one did not recover.

Symptomatology.—We now come to a point where in my judgment all the divergence of opinion which has arisen among writers upon "post-febrile insanity" begins.

There has been a confusion of the stages of delirium with the following insanity; and the confounding of two conditions, which may be related, but are not necessarily so, has caused some writers to consider these groups of cases as identical. Some writers, like H. C. Wood, believe the condition to be wholly due to anæmia and nervous exhaustion; while others, like Korsakoff, regard it an essentially toxæmic condition due to a special poison, such as is developed in beri-beri, multiple neuritis, la grippe, etc., which gives rise to mental confusion, delirium and delusions of apprehension. In all probability, neither view should obtain exclusively. The insanity in many cases is due to shock, anæmia and nervous exhaustion, and the manifestations are generally in delusions of a depressing character. These delusions, even in this class of cases, are not invariably so; because temperament, organization and nervous constitution generally have much to do with the form of mental manifestations, even when the underlying condition of the nervous system seems the same. In other words, of two persons of a seemingly identically exhausted state of the nervous system, one will display delusions of fear and apprehension, and the other will be wildly excited; one may have an inhibition, and the other an exaltation of mental function with extravagant delusions. The governing cause of these differences in symptoms must be the original brain constitution of the individual. There is, however, a distinction between delirium and insanity which ought not to be lost sight of. The essential feature of delirium is mental confusion. Mental concepts arise in the mind in a disordered, illogical manner, and ideas crowd upon each other for expression until all coherence is lost and the mind becomes a rapidly-moving panorama with shifting scenes. Delirium is especially the product of all toxæmic conditions; as is well illustrated by the delirium which follows iodoform, atropia or salicylic acid intoxications. Such delirium, fortunately, is generally of brief duration and disappears with convalescence; but this is not invariably the case, and the morbid mental conceptions may subsequently give rise to systematized delusions. I recall very distinctly a case of chronic insanity, in which the dominant delusion had its origin in the delirium of typhoid fever. When the stage of delirium is not recovered from, and systematized insanity results, there is generally developed great mental confusion along with the insanity; but the association seems almost accidental and to be attributed to the delirium, and not an integral or necessary part of the mental disease. When insanity develops after a fever or other acute disease, mental confusion is not a prominent feature.

Heredity.—Heredity plays an important part. Persons who have an insane or neurotic heredity are more apt to develop delirium or insanity after any exciting cause. Their nervous systems are more impressible and their brain resistance

to disturbing influence is diminished. I do not share the opinion of Glover[9] that heredity is an essential element in the production of post-febrile insanity; because many cases exist where no such heredity can be found.

Prognosis.—In the prognosis of this form of disease much difference of opinion prevails. Physicians who see these cases in general practice regard the prognosis as favorable. Alienists and asylum physicians who see only those which seem to require asylum care by reason of violence of symptoms or their long continuance regard the prognosis as unfavorable. It is possible that alienist physicians see only the more severe cases and hence do not take a sufficiently hopeful view. It is possible also that some of those who are regarded as recovered by physicians in general practice, do not, in fact, recover, but eventually develop fixed delusions and mental impairment. From the histories which I have gathered it is pretty evident that some so called recovered patients were really much enfeebled in mind. Dr. Brush, of the Sheppard Asylum, has mentioned to me the case of a patient who had active delirium during the stage of fever, from which after a tedious convalescence he apparently recovered, but developed, within six months, paretic symptoms. Many other similar cases undoubtedly exist.

Treatment.—From what has been said it is apparent that prolonged delirium adds to the gravity of the subsequent insanity. Hence it is desirable to guard against this as much as possible. For this reason I believe the "Brand treatment" of typhoid fever with cold baths to be especially valuable. It is remarkable how few of the patients who have received such baths develop acute head symptoms and how well the nervous system seems to throw off the effect of the poison. If delirium can be prevented, a factor in the subsequent development of insanity may thus be removed. Something can also be done by rest, quiet and nutrition to prevent the disordered mental manifestations which follow the fever. It is desirable that these patients should not sit up prematurely, and that their feeble strength be not exhausted by company or mental strain. I am of the opinion that the determining element in the production of insanity in some cases is too prolonged abstinence from food. Each case should be carefully watched and food should be resumed as soon as the patient can endure it. Thus much for prophylaxis. For the treatment of the developed disease, rest, quiet, nutrition, remedies to procure sleep, massage, good nursing and careful personal attention, are required. As a rule I would not advise a resort to asylum treatment, because dangerous tendencies are not apt to develop and the step is not imperatively necessary. If, however, it is evident that the case is to run a tedious course, and especially if retention at home is likely to necessitate mechanical restraint, great personal hardships to friends, or confinement to narrow and uncomfortable city rooms, I would advise a transfer to an asylum.

In conclusion, I would say that in my judgment it is desirable that the term "post-febrile" should be restricted to those insanities which follow exhausting diseases, like typhoid and the exanthematous fevers, surgical operations, etc. It should not include the toxic conditions which give rise to prolonged delirium, nor should the name "confusional insanity" be substituted for it, as this element arises from the delirium and is much more applicable to the latter conditions. I would retain the term, post-febrile insanity, and add confusional insanity, to more accurately describe the insanities which arise during the delirium of active disease.

1. Cliniques Medicales, T. I., 1834 (Obs. 53).
2. Maladies Mentales, T. I., p. 73, 1839.
3. Simon—Journal des Connaisances, etc.—quoted in Annales Medico—Psychologique, T. IV., 1844.
4. Remarques sur le Delire consecutive aux Fievres Typhoides—Annales Medico—Psychologiques, 1845.
5. Thore—Annales Medico—Psychologiques, T. VI., 1846.
6. Clouston—Clinical Lectures on Mental Disease, p. 599, 1883.
7. Wood—University Medical Magazine, Dec., 1889.
8. Korsakoff—Allgemeine Zeitschr. f. Psychiatrie, 1889, XLVI, Bd. H 4, p. 475 (Psychosis Polyneuritica seu cerebropathica psychica toxaemica.)
9. Glover—La folie et la fievre typhoide, Paris Thesis, 1891.

DIET AND EXERCISE IN THE TREATMENT OF EPILEPSY.*

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Public interest in questions pertaining to diet and physical exercise has shown a marked increase in the past year or two, and the medical fraternity are realizing the true importance of both in the conduct of individual cases of disease. In the management of various nervous diseases, the value of exercise as an actual therapeutic resource is daily gaining ground. More attention is being given to the development of systems of muscular training, and this increasing interest may suffice as apology for taking up your time in a discussion of the effects, or rather the value, of *diet* and *exercise* in treating epilepsy. Unfortunately I cannot offer you a long record of cases; this dreadful disease has baffled the profession in the past, and while there seems to be a reasonable hope that among some of the new remedies there may be one or more which will do what the bromides do not, the present and future seem almost as gloomy for the poor victims as the past has been. The best we can hope for according to later statistics is 8½ per cent. of cures; the remaining 91½ per cent. are upon our hands looking for some relief, and if we can ameliorate their condition to the extent that we lessen the number of spasms, and preserve the integrity of what mentality is present, we are doing our duty as best we can.

Such information as I offer is based upon observation of a limited number of chronic cases in youthful and elderly patients, with several young children afflicted with the mild form of the disease. All of these cases have been under my care and control for at least twelve months, the larger number for four years. It may not be out of the way at this point to suggest that the epileptic can be treated best while under the direct control and eye of his physician: *habit* has much to do with the recurrence of muscular spasms and the will of a master, with the discipline of a well-ordered hospital-asylum, are helpful assistants to the drugs of the pharmacopœia in reducing the number of spasms and promoting the general welfare of the patient. The physiology of digestion is too well known to need more than passing attention, but before going further it will be necessary to briefly consider the nature of *food* and diet and give some idea of what may be termed physiological exercise. Yeo defines food as "any substance which when taken into the body can minister to the maintenance of its structures and its activities."

"In the widest acceptation of the term," says Parkes, "food includes everything ingested which goes directly or indirectly to the growth or repair of the body, or to the production of energy in any form." Diet is food administered by some rule, generally that of a physician, though the medical man who can map out a dietary upon anything more than a routine basis has learned the art by a study of food values after his graduation, the medical colleges of this country paying but very little attention to this most important line of study. Sir James Paget estimates the total loss of time from sickness in England and Wales as 20,000,000 weeks: much of this illness and consequent loss of time is due to improper food, or proper food improperly cooked and taken at improper times, and can only be prevented by reducing eating and cooking to a science. Materia medica is an important study in all our medical schools; materia alimentarea should rank equally high in importance.

Food is taken into the organism to supply the loss from the daily wear and tear of bodily functions and labor, to furnish heat, to supply energy. It is un-

*Read before the Medical and Chirurgical Faculty of Maryland, April 28, 1892.

derstood by those who rank as authorities upon such subjects that those who are employed in the most laborious work need a richer dietary than those who are idle, that growing children need a diet adapted to their rapid physical expansion, that the aged need *less* food than the youth or middle-aged man, that the man who works his brain at the expense of his muscular system must have a specially constructed diet.

In formulating the diet of our epileptic patients we have to consider those of different age and those of different habit. I think if it is possible to oversee the bill of fare, week in and week out, for years at a time, there are many epileptics who may be permitted nearly everything that anyone else eats, excluding only such articles of food as are known to be indigestible and guarding most carefully against over-feeding. We shall meet some cases who cannot eat certain things without danger of a spasm—for instance, I have a child nearly thirteen years old who has not had a spasm for more than a year, yet if she should eat a teaspoonful of common beans, no matter how well cooked, it would I am sure precipitate one or more convulsions; in this case there seems to be a personal idiosyncrasy in regard to this vegetable, though a sudden fright as an external agent has induced a severe fit in the same child. There are some epileptics who cannot take milk in any form, some who do not like acids, but as a rule their appetites are fully up to the standard and their desires ganged only by their opportunity to crowd food down their throats. Be it understood that I am speaking of epileptics who are more or less defective mentally.

In dieting the epileptic the first point to be considered is *regularity*. Such patients, at home, if afflicted with so-called good appetites, are allowed to feed at will, and I must say the ease with which they can swallow enormous amounts of food and pass it on through their intestinal tract without apparent suffering or injury is marvellous. That an overloaded stomach will bring on a fit or fits is, I think, unquestionable, and the stomach to which additional supplies are being made at short intervals is in an even worse condition than the stomach simply overloaded, for when digestion ceases fermentation and decomposition commence and the irritation increases proportionately. We are dealing with patients who may never have known restraint upon their desires, and for them we make a stringent rule—nothing to eat except at meal-time.

Another point is, eating properly. It is said that Gladstone gave every mouthful thirty-two bites before swallowing the bolus, and while this is all very well for those who will do it, it would be an impossibility to insist upon such a plan with our patients. They may, however, by constant and careful attention, be trained to eat slowly, chew their food thoroughly and properly and use their knife and fork in a manner acceptable in polite society.

Some have the very disagreeable habit of using their incisor teeth as molars, and much time is taken up in teaching them to roll the bolus of food from side to side and use the back teeth to disintegrate the mass and thus thoroughly mix it with the saliva before it is swallowed.

It should not be difficult to undertand the condition of a stomach into which the material of a meal has been introduced in lumps and almost solid masses; the mixture of an ordinary meal is bad enough, without giving the stomach the additional duty of chewing the food as well as digesting it; it is also an easy task to demonstrate the subsequent irritation of the above condition upon sensitive nerve masses, only needing a slight inducement to explode in a wild outbreak of nerve energy, as well as the future results upon the stomach itself and the general nutrition, and further argument for proper table decorum is unnecessary.

Quantity is an important consideration when it is known that those who eat are not capable of measuring the limit of their desire for food by any reasonable standard. Those whose temperament and ability permit them to take active exercise or engage in regular work which calls for an expenditure of muscular force, naturally need more food either in quantity or quality than those who are feeble, or those who by reason of their mental obliquity are disinclined to exert themseves. The boys and girls who are approaching puberty, whose physiques are in that transition period between childhood and womanhood or manhood, need more proportionately than the older persons who have attained their full physical growth.

Sir Henry Thompson† speaks of that period of youth "when the whole system abounds in vigor and strength, much superfluous food may be disposed of—first, by the greater activity of the functions of digestion and absorption, and secondly, by the capacity youth possesses for excessive muscular exercise, by which it can use up and eliminate such excess almost at will." While, however, the system of youth can overcome the effects of overplus, for a time, there must come a time when the relation between the "income" and the "out-put" must be maintained with more care or the many and varied evils of over-feeding begin to show themselves.

It will be found an easier task to keep the average man nearer the normal under a regular and somewhat limited diet than to maintain a close average of health upon an irregular and unlimited diet.

Quality of the food bears a very distinct relation to the value of the diet. Not in the sense of cost price, for that varies with the condition of the market and the amount purchased, while to the institution which raises its own supplies the cost is reduced to a minimum. But food has certain values reckoned upon its chemistry. It may be divided into :

I. Organic. Nitrogenous: *a*, albuminates. Non-nitrogenous: *a*, fats; *b*, carbohydrates.

II. Inorganic. Mineral: *a*, mineral.

It is a proper proportion of organic and inorganic, nitrogenous and mineral albuminates, fats and carbo-hydrates supplied to the organism that enables metabolism or assimilation to take place; the term metabolism also refers to that power which the animal organism possesses of accumulating from its food supplies a store of potential energy which it afterwards transforms into kinetic energy or muscular work and heat; it also takes into consideration the excretory products resulting from the changes which occur in the constituents of the tissues as the necessary accompaniment of such transformation of energy.

Normal metabolism requires a due supply of suitable food; it involves the storing up of a certain part in the body; it demands a regular chemical transformation of the tissues and the formation of the effete excretory products resulting from these changes which have to be eliminated through the organs provided for that purpose.

Equilibrium of metabolism means that the bodily income and expenditures are balanced; that while the normal physiological conditions are maintained, there is exactly the same amount of new material absorbed and assimilated, as there is of effete matter, the product of the retrogressive tissue changes, removed by the organs of excretion; the destruction of tissue is exactly compensated by the formation of new tissue. While the body is growing rapidly there is greatly increased formation in the parts participating in the rapid growth and the metabolism in these parts is correspondingly increased; on the other hand, during senile decay the expenditure is in excess and the body in consequence wastes.

†Diet in Relation to Age and Activity.

The physiological equilibrium is practically determined by weighing and observing that the body remains of the normal weight with a given diet.

In working out any problems with the defective class in question it is not easy to determine a standard, the variations in weight and height for the same age being only limited by the number of individuals weighed and measured; it is therefore hardly fair to draw more than tentative conclusions from data made up from comparison with normal individuals of the same age.

Curiously enough, very few of the authorities pay much attention to the question of diet when writing of epilepsy. Nearly all coincide with the opinion that meat is hurtful, and push this forward with some emphasis. Hare, whose monograph upon the pathology and treatment of epilepsy is one of the most thorough and comprehensive upon that subject ever published, claims that very little has been done in the way of observing the effects of diet upon any large number of patients. He mentions a report of 24 cases, 12 being placed upon a purely vegetable diet, 12 upon a purely nitrogenous diet, for a period of two months, with a result that the vegetarians had a few less spasms than the others, but the difference was so slight as to be almost of no weight in determining the question.

I myself have been unable to put more than a limited number under observation; the six cases of my own were all chronic cases, in which the possibility of cure had been abandoned, and we only endeavored to reduce the number of spasms to minimum and keep the general conditions of each as close to the normal as possible. Each one was taking sixty grains of potass. brom. daily in four doses. For six months meat was eliminated from their diet, a full regimen of vegetables, cereals and fruits, with brown, white, and corn-bread without eggs being given; meat, eggs and milk were then added to the diet list for another period of six months, careful attention being given every month to the weight, and any variation below that of a preceding month being met by an additional portion of fat-making food. Comparisons between the number of spasms for each month of one period and the corresponding month of the other, and the totals of the two periods, gave decidedly negative results, though the average of the six months of vegetable diet was slightly lower than that of the more general diet. The variation in number of spasms was, however, only that which may be seen in any number of chronic cases under close observation.

Further observation has led me to believe that in such old cases *diet* has only a subordinate effect upon the fits, and it would seem that so long as care is taken to eliminate any article of food known to be indigestible and to prevent over-feeding, a good, generous and varied bill of fare is the best. In cases where the general health is good, a diet very similar to that prescribed for athletes under training is advisable: for the growing child a fat and blood-forming dietary, and for the elderly and apathetic the most simple and easily digested articles. Monthly comparisons of weights will show losses and gains, and thus permit any necessary change in the amount or nutritive value of the food.

There seems to be much misunderstanding as to what a generous diet means. The parents of our epileptics so many times protest that their child is kept upon the plainest possible diet, investigation showing the statement in some instances to be correct, but the patient is permitted to eat *all that he will*, under a very mistaken idea that because he wants it, his wants are actual needs; in other instances the so-called plain diet is perhaps not a series of dishes fit to set before a king, but really a rich and highly spiced bill of fare, entirely unsuitable to a stomach which must not be over-burdened, no matter what its capacity. Other

parents condemn a diet which, as they say, prohibits cake, candy, pastry and unripe fruit, or fruit known to be indigestible, and their poor child has so few pleasures in life, it is a pity to deny him such things. The taste for sugar is no doubt physiological and should be gratified, but candy may be given judiciously, just as well as a dessert, as to permit the child to eat it at any or all times. So with fruit, though to my mind the swallowed pulp of oranges and half-chewed bits of bananas have been responsible for many a convulsion, and such pleasures are surely a mistaken idea if we are to obtain a cure.

Unless combined with a certain amount of exercise, diet is of an uncertain value; that is, the amount of food ingested to preserve the physiological equlibrium of metabolism, must be modified. Parkes says of exercise, "A perfect state of health implies that every organ has its due share of exercise. If this is deficient nutrition suffers, the organs lessen in size and eventually degenerate more or less. In common with his more fortunate brother imbecile who is not afflicted with epilepsy, the epileptic defective is more or less imperfectly developed physically; narrow chests, drooping shoulders and ill-developed muscles, so frequently complicated with paralytic deformities, are very common.

Very little can be done with the shrivelled, useless, paralyzed extremities, though I have seen much improvement in some cases, where the muscles had not atrophied, from properly directed exercise, especially in the lower extremities from the use of a tricycle.

Graeme M. Hammond, M. D., of New York, in a recent number of the *Journal of Mental and Nervous Diseases*, has a very interesting article upon the bicycle in treatment of nervous diseases, in which he cites thirteen cases particularly benefited by riding a wheel under direction. In this connection, Hammond says of exercise, "Exercise, when prescribed for nervous affections, should preferably be taken out of doors. It must be combined with pleasure and should be prescribed not only with a view of strengthening the muscles, but also for its effect upon the mind. The effect upon the mind is often of greater importance than the effect upon the body. The feeding of the mind on self, and the continual mental introspection which is so common in neurasthenia, hysteria and hypochondria should be combated by prescribing an exercise which necessitates the pleasurable concentration of the mind on what is being done, something which demands a certain amount of skill for its successful accomplishment and which must therefore divert the thoughts from morbid channels, stimulate the mental faculties in a normal direction and engender a feeling of brain-rest and mental refreshment."

The value of exercise as pointed out by Dr. Hammond in benefiting certain forms of nervous disease not complicated with spasms is equally marked in the treatment of epilepsy, though of course the method of exercising must be modified, or rather adapted, to a disease which manifests itself by throwing the victim out of his equilibrium. All varieties of exercise where the patient's life or limbs will be endangered must be thrown out of discussion.

The daily risk of danger from falling is sufficiently great without adding anything more. We want in these cases a series of exercises calculated to develop the entire muscular system symmetrically, correct any physical deformity as far as possible, and add nothing in the way of risk from a sudden fall. In beginning systematic exercise with younger patients, the Swedish system of educational gymnastics, some description of which has been given this Faculty, is invaluable in educating the young, growing muscles for more complicated exercises, giving the best possible results with the least exertion, stimulating not only mus-

cular, but mental development as well, overcoming in a measure the muscle habit of involuntary contraction as seen in the epileptic fit, and generally promoting the physiological action of the internal organs.

Epileptics suffer from obstinate constipation which is extremely difficult to overcome by ordinary treatment, and I am of the opinion that the acne of those who are taking the bromides constantly is in many cases due as much to irregular action of the bowels as to any direct effect upon the skin by the drug; this constipation, skin trouble and the depression seen in some cases where larger doses of the bromides are being given may be cured in most cases by gymnastic and other active exercises, and there is rarely a case so stubborn that it is not at last benefited. One of the most important effects of exercise is produced upon the lungs. It is well known to those whose practice involves a close acquaintance with the chest capacity of the average man that few utilize the entire compass of their lungs; especially is this seen in these defectives. Now, if the observations of Valentin and Sczelkon are correct—that the greater part of the carbon dioxide which the respiratory organs throw off is formed in the muscles, exercises which shall strengthen respiratory effort and increase the lung capacity should be faithfully followed out. Indirectly exercise may exert very valuable effects upon excitable nerve centres, as well as act positively in eliminating the waste products of the entire body.

Motion, especially such as may be made toward some pleasurable end, and active work which brings with it some reward, will often break up a beginning epileptic mania and I am satisfied that all epileptics should be kept as actively employed as their condition and environment will allow.

Walking is as suitable an exercise as can be given. No extra machinery is needed and the effect can be readily studied many times. It must be compulsory and the distance increased as the muscles permit. In these days of rapid transit the legs are becoming a secondary means of propulsion, whereas they should be the chief.

Americans are celebrated the world over as a nation of dyspeptics. It is certain that we are a nation who use every available means of getting to our journey's end with the least possible physical exertion and in the shortest possible time; and the query arises whether the dyspeptic symptoms would not vanish with a revival of walking as a popular method of travel.

Foot-ball is another method of overcoming the inertia of our patients by a pleasurable game; the striking-bag of the pugilist may also be utilized for those who can stand the violent exercise; the modern wall-machines offer very elegant and very effectual means for developing the muscles. But all such exercise, whether easy or violent, must be guarded by a watchful and intelligent teacher, lest more harm accrue than good.

That diet and exercise are but subsidiary means in the treatment of epilepsy must be admitted; that they are valuable corollaries to such drugs as may be prescribed is I think equally true. But unless properly prescribed and administered their therapeutic value diminishes.

The time will come probably when a large majority of our epileptic population will be gathered together in branch asylums connected with our State institutions for the insane and feeble-minded, or in private asylums devoted to that class of patients, and it is from these asylums, where the patients are under the eye and training of a medical officer who has himself been trained in physical culture and made a study of diet, that results are to be had worthy of study; until then we are, so to speak, in a realm of theory.

The older and chronic cases are of course beyond cure and almost beyond ameli-

oration; but there are many cases of young children among whom, if taken in time, removed from home environment and placed under discipline, carefully studied physically and mentally, thoroughly drilled in exercises calculated to increase muscular development and develop muscular control, with less attention paid to teaching book knowledge and more attention paid to training in habits of obedience and decorum, I take it that more might be cured; and certainly the care of the incurable would become a simple problem. It may, I think, be reasonably concluded: That diet and exercise are important auxiliaries in the treatment of epilepsy. That diet should be, as the term implies, food prescribed by a physician. That an extreme opinion either for or against a dietary consisting entirely of nitrogenous matter or, on the other hand, strictly vegetable, is entirely wrong, and a middle opinion which will give the patient thorough study and afterwards arrange the diet according to the patient's physical needs is the proper theory. That exercise should also be prescribed by a physician and followed out under his eye as far as possible, particular attention being given to exercises calculated to develop respiratory action, strengthen the heart and generally promote muscular control.

WHITE STOOLS.

The fact of persistent white stools being passed when the patient is on a mixed diet raises the question whether colorless motions necessarily imply absence of bile. Dr. Walker, of Peterborough, has shown that when the pancreatic duct is obstructed white stools result, and argues therefrom that the pancreatic secretion is a necessary ingredient of the coloring matters of the fæces. In the only necropsy of a case of psilosis which has been reported, the liver, pancreas and their ducts were all normal. Dr. Wynter Blyth made an analysis of the stools of a patient of Dr. Thin's, and showed that more than half of the organic solids consisted of neutral fats, apparently milk fat, which had passed without being digested or saponified. Nearly 6 per cent. of bile acids were present as soap, thus showing that bile was not altogether wanting. As the fat in the stool was only a fraction of the quantity taken in the milk, it followed that a considerable portion of the milk fat had been digested, thus affording clinical evidence of the presence of the pancreatic secretion. In fact, milk is the only diet that many of the patients affected with this disease can take.

The practical importance of these observations is obvious. It has generally been held that colorless stools denote serious interference with the functions of the liver or pancreas, either due to disease of the organs themselves or to obstruction of their ducts. We see, however, from the observations which we have just considered, that such is not necessarily the case; and it is a question well worthy of serious consideration whether in numerous other cases we are right in concluding that the liver and pancreas are not acting normally because this symptom (colorless stools) is present. Dr. Thin suggests that the coloring matter of the fæces in psilosis is destroyed low down in the intestinal canal by bacterial action, and until some other agency has been discovered or this theory shown to be untenable we must conclude that the views hitherto held as regards the white stools, although probably correct in the majority of cases, are not complete, and that further investigation is necessary before the matter can be considered to be satisfactorily settled.—From Editorial in *Lancet*.

The Second Annual Meeting of the American Electro-Therapeutic Association will be held in New York, October 4th, 5th and 6th, 1892, at the New York Academy of Medicine, 17 W. Forty-third Street. W. J. Morton, M. D., President, H. R. Bigelow, M. D., Secretary.

THE MARYLAND MEDICAL JOURNAL.

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BALTIMORE, MAY 28, 1892.

Editorial.

THE PROTECTIVE INFLUENCE OF FADS.

There is in every community a certain percentage of cranks. Some of these cranks are lacking in energy and unworthy of consideration. Others, however, are full of energy, possessing restless minds which demand occupation; yet they cannot or will not steadily pursue useful callings.

These individuals are a power for evil in the world; many of them being highly educated, and a few having even a spark of genius. Their dominant passion is vanity. They must be continually attracting attention to themselves.

Some do this by posing as invalids—how successfully, the physician who deals much with the hysterical crank well knows. Others gain their ends by continually engaging in sensational enterprises. They are forever starting or following after some new fad.

In religion it is some "sophy" or "-ism" full of mysticism or emotionality. In politics it is some violent subversion of existing order. In medicine it is a new "pathy" with a theory or agent which is, singly and unaided, to solve without delay or difficulty all the multitudinous problems of therapeutics. In whatever sphere, experience, logic, science, common sense, are treated with lofty scorn, and those who refuse to abandon them for the new fad are held up before the public as prejudiced or old-fashioned.

As the public want sensations to enliven the monotony of daily life, each new fad obtains a following, until its successor appears and quickly eclipses it.

Now, what we contend for is, that mild fads ought not to be dreaded or treated with more attention than they deserve by persons of well-balanced minds. The mild fad occupies the attention of the crank portion of the community, and protects the public from more serious outbreaks of crank energy. The Guiteau who is enjoying the excitements of the Oneida community may shoot a President if he is compelled to seek a new sensation. The woman who parades in bloomers

might, if restrained from this innocent amusement, take to throwing bombs. Theosophy is better than Moloch worship. The honest "thirtieth dilution" therapeutist might be dangerous to the community if he handled powerful drugs. The Thompsonian fad, when it took hold of the public mind, was less fatal than the great blood-letting delusion.

Let us view with equanimity the milder delusions of the day. Like epidemics, they must come, because persons of great energy and little mental balance are always to be found, and the public mind seeks ever to be amused. But as influenza is better than "black death," so Christian Science and the like are better than some other medical delusions which have been in the world. The crank must have occupation, therefore deal tenderly with him when he finds it in a comparatively harmless way.

THE JOINT-STIFFNESS WHICH FOLLOWS GONORRHŒAL RHEUMATISM.

At the last meeting of the American Orthopedic Association, Dr. Brodhurst, of London, read a short paper (see Book Review column of our last issue), in which he urged that stiffness of joints after gonorrhœal rheumatism may be prevented by bringing the patient, early in the disease, rapidly under the influence of mercury. If stiffness or ankylosis has already occurred, he holds that motion may always be restored without injury to the parts. If tenotomy is necessary the wound should always be allowed to heal before flexion is attempted, else a long tear may be made. Anæsthesia is sometimes necessary. In breaking up the adhesions force should be applied only in the direction of flexion. If extension force is used, great damage may result.

POTT'S DISEASE AND PREGNANCY.

Dr. T. Halsted Myers read an interesting article on this subject at the last session of the American Orthopedic Association. His conclusions were that the action of the voluntary expulsive muscles of labor was feeble in proportion to the deformity, on simple mechanical principles; but that the involuntary muscles were very little hindered.

Active Pott's disease of the dorso-lumbar region is apt to greatly increase in severity during pregnancy. He has known of no instance in which pregnancy has rekindled disease of the lower dorsal, lumbar or sacral vertebræ which had been *cured.*

During pregnancy, the weight of the uterus and its contents acts injuriously upon the diseased spine. Gestation also involves spinal congestion, and so predisposes to disease-action.

The New Medical Law, which was passed by the last Legislature, has been reprinted from this JOURNAL, and can be had by sending ten cents, addressing **Journal Publishing Co., 209 Park Avenue, Baltimore.**

Special Abstracts.

HYDROCHLORIC ACID IN THE TREATMENT OF VOMITING.

Dr. Alkiewicz, writing in the *Nowiny Lekarskie*, says that in various kinds of vomiting he has found great benefit from small and frequent doses of hydrochloric acid. In one case of the vomiting of pregnancy, where none of the ordinary remedies had any effect, hydrochloric acid proved successful, although it had to be given for a fortnight before it entirely arrested the sickness. In more than ten cases of cholera nostras in adults, with vomiting, hydrochloric acid was given with good results. Again, where vomiting was due to acute dyspepsia from errors in diet, and where it occurred in the course of influenza, scarlet fever or other contagious diseases, the same remedy proved equally efficacious.—*Lancet.*

THE BACILLUS OF MEASLES.

The *Berliner klinische Wochenschrift*, of April 18th, contains a paper by Drs. P. Cannon and W. Pielicke, assistant physicians to the Moabit Hospital, Berlin, stating the results of their bacteriological investigation of measles. In the examination of stained specimens from the blood of fourteen patients suffering from measles, they have found in all cases the same bacillus. The bacilli—which are found in every stage of the disease, more abundantly, as a rule, in the period of defervescence—occur also in the expectoration and in the nasal and conjunctival mucus. With the exception of bouillon, various nutrient media inoculated with blood from the patients remained sterile. In some cases the bacilli grew abundantly in the bouillon, but were incapable of further cultivation. Further results from these investigations and from others will be awaited with interest.

PALLIATIVE TREATMENT OF CANCER OF UTERUS.

This treatment, suggested quite recently by Dr. H. Schulz, assistant to Dr. W. Tauffer, Professor of Obstetrics and Gynæcology, Buda-Pesth, consists in the injection of absolute alcohol into the substances of the cancerous tumor. The patient having been placed in the lateral decubitus, Sim's speculum is introduced; then, having protected the urethral orifice against the caustic action of alcohol by cotton, five grammes of absolute alcohol are injected at varying depths into the substance of the tumor. The greater part of the liquid injected escapes from the tumor, carrying with it a large quantity of detritus and shreds of necrosed tissue. The injections are made at first every two days, then daily. The results so far seem to be very encouraging, judging from the eight cases in which Dr. Schulz has employed the injections.—*Bulletin Général de Therapeutique.*

TREATMENT OF CANCER.

Under this head Dr. G. Sims Woodhead, in the Morton lecture on the Etiology of Cancer, says: "From a careful microscopical investigation of many hundreds of cancers that have been submitted to me for examination, I am firmly of the opinion that many surgeons make the mistake of not removing sufficiently freely either the tissues in which a cancerous growth has made its appearance or the lymphatic glands associated with it. Quite recently Mr. Harold Stiles, of Edinburgh, has carried on an extensive and careful investigation into the question of how far the immediate tissues around the naked-eye cancer of the breast are affected. His method is based on the effect which nitric acid has upon the tissues, causing the connective tissue to become clearly differentiated from the epithelium. From a careful study of sections so prepared, both by Mr. Stiles and myself, as well as from microscopic examination, I am convinced that the

only safe rule to be observed in removing cancer of the breast is to remove not only the main mass of the gland, but all outlying portions of glandular tissue; so that if, on cutting away the margins of the tumor, treating with methylated spirit and nitric acid, and then with water, any opaque columns or fragments are to be seen still, I should consider that the removal had not been free enough. Of course, the part of the tumor that should be especially examined in such a case is that near the sternum, where, by reason of the shape of incision usually adopted, there is the greatest danger of fragments of the gland being left."

TREATMENT OF PYOGENIC AFFECTIONS BY PRODUCTION OF ARTIFICIAL ABSCESSES.

Fochier (Lyon) has recently suggested the production of artificial abscesses, by the subcutaneous injection of essence of turpentine, as satisfactory treatment for certain cases of infection. In a number of grave cases of puerperal infection and of pneumonia, he thinks he has seen recovery due entirely to this treatment. Dieulafoy (*Sem. Med.*, March 30, 1892) reports a desperate case of pneumonia successfully treated by Fochier's method. In his case subcutaneous injections of 1 gramme of essence of turpentine were given in each of the four limbs; the following day there was marked improvement in the condition of the patient. L. Bard (*Lyon Méd.*, April 17, 1892) reports a grave case of pneumonia where recovery was undoubtedly due to the production, artificially, of abscesses.

Medical Progress.

THE CAUSES OF JAUNDICE.

In his Lumleian lecture, Dr. Pye-Smith (*Lancet*, April 30th) speaks thus of the obscurity which still shrouds this familiar condition: With respect to its etiology, it is remarkable how little has been accomplished since morbid anatomy and animal chemistry began to be studied. It is little more than a century since the foundation of pathology, as a science of facts apart from speculation, was laid by Morgagni, and the knowledge of the chemistry of bile began with Berzelius; yet Boerhaave and Mead were not more ignorant than we of the cause of the most characteristic and remarkable form of jaundice. They, like us, could understand how when the duct of a gland is blocked by a calculus the secretion accumulates, distends the channels in which it runs, and is thus mechanically detained in the body. But we, like them, cannot explain jaundice without obstruction. Even in the case of obstructive jaundice much remains to be learnt as to the nature of cholæmia. If the bile, or any of its constituents, is so poisonous, why does it circulate for weeks and months without producing its effects? If it is innocent, why are those effects produced at last? In either case, why is a manufactured excretion reabsorbed when the factory is reduced to ruins and the exit unimpeded? and why, in this case alone, are the symptoms of cholæmia as constant and speedy as in other cases they are tardy and uncertain? But it is the cases of jaundice which—by an almost subjective use of the word—we call simple, that are so puzzling in their etiology. We surely cannot be satisfied by the current explanations—which refer icterus simplex to obstruction by inspissated mucus, which no one ever saw; or by swelling of the duct or of the duodenum, of which there is no proof; or by the pressure of impacted scybala, of which the presence is entirely hypothetical. Do we find anything analogous in the case of the kidney, the pancreas, the mamma, the parotid, or the lachrymal gland? In many cases of jaundice is there the slightest evidence of duodenal catarrh or of preceding

obstipation? On the other hand, do we not frequently see evidence at the bedside, and proof after death, of considerable catarrh of the duodenal mucous membrane, and sometimes of fæcal accumulation in the transverse colon, and yet never jaundice? I might also adduce the youth and health which usually mark the patient, and ask why the supposed cause of obstruction should, after a limited duration, disappear as mysteriously as it came. Nor do we gain any help in explaining the cause of simple jaundice from Frerich's hypothesis of virtual obstruction, owing to blood pressure being extremely low. In the first place, there is not the slightest evidence that in these cases blood pressure is lower than usual; in the second place, we know that the pressure in the duct of a gland is often higher than that in the blood vessels which supply it, without secretion being suspended or reabsorption taking place; and, lastly, when we do know that the blood pressure is abnormally low, as in prolonged syncope, in anæmia, and in distension of the right side of the heart from the pulmonary obstruction, we do not meet with jaundice. The only case in which it does coincide with low pressure in the portal vein and high pressure in the hepatic is that of long continued organic disease of the heart, when we find evidence of mechanical pressure on the biliary ducts.

Surely it is better, instead of accepting vague hypotheses, which it is impossible either to prove or disprove, to regard jaundice, in the absence of demonstrable obstruction, as due to some other and as yet unknown condition. We shall thus at least regard each case we meet with in daily practice as a problem to be solved, not as an example of a well understood physiological process. The fact is that, in spite of the great advances in our knowledge of secretion, among which are preeminent those due to our distinguished Bailey medalist, Professor Heidenhain, of Breslau, much still remains to be done. The physical and chemical process, which ten or fifteen years ago seemed so beautifully clear—the blood, the basement membrane, and the secreting protoplasm, regulated by its vaso-motor and secretory nerves—though a true, is now found to be an inadequate, physiological conception. The unexpected results of partial removal of the kidneys and of complete removal of the pancreas in animals more closely allied to man than frogs or rabbits offer new problems—we may almost say new paradoxes—in physiology, which seem as hard and, so to speak, illogical as any that we meet with in disease.

NEUROTIC CONSTIPATION.

In his Harveian lecture (*Lancet*, February 13th) Dr. Goodhart, of Guy's Hospital, says: Coming next to constipation, it is hardly necessary to insist that there are two predominant factors in its production—the influence of the nervous system direct, and the influence of habit. The influence of the nervous system shows itself by a phlegmatic reaction to the natural stimuli, and this may be either an action natural to the individual; or an unhealthy one, due to a lowered vitality of the centres involved. There is no difficulty in establishing the power of the nervous system to determine the complaint when we consider how in several morbid conditions—melancholia in particular, but in hemiplegics, acute and chronic inflammatory conditions, and so on—one and the other keep time together; and there can be no question that, although the derangement of the bowels is an important element for consideration in promoting the cure, the morbid condition of the nervous system precedes. It is with the bowel as with the stomach; as in a case already noted, the sleeplessness always *preceded* the flatulent dyspepsia. Moreover, who has not seen several times the milder forms of nerve disturbance —the simple depression of spirits, the transient glycosuria that occurs in the

overworked, etc.—closely followed by obstinate constipation? It is often thought that the benefit that accrues on a good clear-out shows that some of these states are the result of fouled flues. No doubt this is so sometimes—it cannot be always; and there is no doubt that the intestine, as regards constipation, is a highly sensitive organ from which we can very often read the temperament or disposition of the man. But that is not all; it is an index of the state of nervous tone and vigor of the patient; and there is many a state of constipation that is not a case for aperients at all, but requires the liberal use of tonics. But I have something to say also on the subject of habit. It is obvious that the repeated recourse to aperients conduces to constipation and engenders a habit, but perhaps I may say this also—that, impressed as we all become as years go on of the primary importance of maintaining the purity of the primæ viæ, we sometimes forget in our advice to the patient that aperients are, after all, only a makeshift, and that they are an evil unless the good they do is undoubted. But the point I wish to make is this—that I have often been told by the chronic piller, as an excuse for the persistence in his practice of pill-taking, that he cannot leave it off, because if he does he never has a satisfactory evacuation. He appeals, in fact, to the habit he has cultivated. But I maintain that in some cases he has not fully considered the question, and that he is not always right. And for this reason. The chronic exhibition of aperient drugs, which are in most cases irritating, engenders a state of periodical excitement in the peripheral nerve endings of the intestine, and ultimately raises the unnatural condition to a natural one for them. When this time has arrived, the bowel may be described to pass through the periods of hunger and periods of satisfaction according as it is being tickled by the drug that has been given or not. The condition is on all fours with the opium-eater's sensorium, and the bronchial tubes of the chronic asthmatic under the influence of repeated inhalation, and the mucous membrane of the habitual snuffer. And this state extends through the whole length of the intestine probably; but in the present case it is the lower bowel that conveys the sensation of a satisfactory evacuation or not. If it feels the bite of the stimulant, then the individual, through his local sensations, describes himself as satisfied; when the bowel is not under the influence of the stimulant, then there is no adequate sensation of a good clearance, and the patient takes his ease in his discomfort. The bowel, like the stomach, takes kindly to good living; but when it has been used to the luxury of such dainties as compound colocynth pill, calomel, aloes, and such like, it, no more than the stomach that has been fed on highly seasoned foods, likes to be deprived of them. The rectum is a very pretty judge of quality, but a very poor one of quantity. So that when a patient, after such means as this, takes to Carlsbad salts and mineral waters and says that they do him no good, and that he must go back to his old remedies, all that he really means is that he cannot control the wishes of his lower bowel any more than the opium-eater can control the craving of some other part, or the alcoholic his cravings.

But it is not only in constipation that the neurotic tendency of the bowel comes into play. It is even more strikingly seen, if not quite so often, in the explosive diarrhœas that are common in children, and sometimes dog the steps of the individual even to adult age. I can well remember having for some time as one of my out-patients at Guy's Hospital a poor feeble neurotic patient who was in this unhappy condition—that if anyone suddenly came behind him in the street and clapped him on the back with a "Hulloa! how are you, old fellow," his bowels would promptly act. I have never seen another case so bad as that: but I have seen several where they had to walk circumspectly; and the well-recog-

nized condition where the mucous membrane of the intestine seems to be oversensitive and reacts energetically as soon as food enters the stomach is a similar state of things, and an indication of a temperament. It is certaintly a neurotic condition, and may be remedied, as so many of the too sensitive conditions of the nervous system may be, by tonics in part, but much more, I think, by tonics with minute doses of opium added to them.

A CASE OF GENERAL FATTY DEPOSIT.

In an article entitled "Our Mistakes" (*Lancet*, May 14, 1892), Dr. Murray says:

Let me give a history of a case illustrating the extreme difficulty or impossibility of arriving at a certain diagnosis. I do so the more readily because I believe the case is unique.

Some years ago the late Mr. John Hope and I saw a patient suffering from intolerable pain in the testes. Both testicles were enlarged, the left as large as a goose's egg, the right slightly smaller. As the enlargement and sufferings increased, especially on the left side, we decided to remove that testicle. On doing so we found a healthy testicle encased in dense concentric layers of suet-like fat about an inch thick. The relief obtained made the patient urgent to have the right testicle removed too, which was done with complete relief. Some months afterwards this man came to me again in a deplorable condition. His body was emaciated, but the abdomen had become enormously enlarged and extremely painful. The abdominal swelling was uniform and dough-like on palpation and absolutely dull on percussion, without any evidence of fluctuation. His chief symptom was a mucous diarrhœa over which remedies had but slight control. He died of exhaustion. On making a post-mortem examination, we found the enlargement was entirely due to the presence of hundreds of fatty tumors scattered throughout the folds of the peritoneum. The mesentry was a mass of them. They varied from the size of a pea to that of an orange, and each was composed of concentric layers of suet-like fat similar to that found around the testicles. The smallest were concentric as distinctly as the largest. The most remarkable developments were in the appendices epiploicæ, each of which extended into the abdomen like a large bunch of grapes studded with fatty nodules. We might, if we had had a similar experience, have defined from the testicular encasements the real cause of the abdominal enlargement; but, lacking this, I think it was impossible to make a sure diagnosis.

CYSTS OF THE TONSILS.

Dr. McBride, of Edinburgh, writing in the *Brit. Med. Jour.*, May 14, 1892 ("Cysts of the tonsils, nose, larynx and ear"), says;

A careful perusal of English, American, and Continental works on throat diseases will reveal the fact that cysts of the tonsils are rarely if ever mentioned. It is, however, quite common to meet with small whitish-yellow areas, both on the glands themselves and their immediate neighborhood. I do not refer now to the cheesy accumulations which are often found partially extruded from a mucous follicle or crypt, and which are easily pressed out as cheesy ill-smelling plugs. In the class of cases to which allusion is intended, the deposit is covered by a layer of mucous membrane, and the appearance presented is, owing to this fact, somewhat similar to a pointing pustule. Careful inspection reveals, also, that the yellowish area bears upon its surface a fine vascular network. After puncturing and exercising a small amount of pressure on the adjacent parts, a somewhat cheesy nodule of white color becomes extruded, differing only in the absence of fœtor from the cheesy masses above referred to. The condition just

described is practically a cyst due to retention of exuded matter and desquamated epithelium, either within a gland or a crypt. I have, however, met with very definite *retention cysts in the tonsils* on two occasions. In both cases the patients were females. In neither was pain complained of, but only discomfort. On the affected tonsils was seen a yellowish-white area of considerable size over which small vessels ramified. Incision gave exit in each case to about a drachm of cream-like fluid, resembling pus, and without any odor or even bad taste. In my first case I immediately excised a considerable portion of the outer wall, while in my second I contented myself with evacuating the retained secretion, and telling the patient to return if any renewal of discomfort ensued. In the former I know that a perfect cure resulted, while, as the latter has not returned with any complaint, I presume that a similar result followed simple incision in her case.

These cases have appeared to me of sufficient interest to record, because both from my own experience and from my reading I believe them to be extremely rare. The etiology of such cysts can be very simply explained. Although in the human subject it is doubtful whether glands usually discharge into the crypts, yet we must remember that within them there is constantly occurring a destruction of the epithelium and an exudation of leucocytes presumably associated with more or less fluid. If, then, owing to previous changes of an inflammatory nature, a crypt has been changed into a closed cavity, we may expect it to become filled with creamy contents, such as were present in the two cases just described.

In the naso-pharynx cystic formations may occur in exactly the same manner. Tornwaldt ascribed them to retention of fluid in what he described as the bursa pharyngea. It is now, however, believed that this cavity, when present, is merely a result of inflammatory changes in one of the furrows of the pharyngeal tonsil.

Medical Items.

The American Electro-therapeutic Association will hold its second annual meeting in New York, at the Academy of Medicine, on October 4th, 5th, 6th, under the presidency of Dr. W. J. Morton.

The American Neurological Association will hold its annual meeting in New York, at the Academy of Medicine, on June 22nd, 23rd and 24th, under the presidency of Dr. C. L. Dana.

Professor.—"What has become of Tom Appleton? Wasn't he studying with the class last year?"

"Ah, yes; Appleton—poor fellow! A fine student, but absent-minded in the use of chemicals—very. That discoloration on the ceiling—notice it?"

"Yes."

"That's Appleton."—*Western Medical Reporter.*

The officers of the American Pediatric Association, elected for the ensuing year are: President, Dr. Blockader, of Montreal; 1st Vice President, Dr. Keating; 2nd Vice President, Dr. Earle, of Chicago; Secretary, Dr. Samuel Adams, of Washington; Treasurer, Dr. Towsend, of Boston; Recorder, Dr. Watson, of Jersey; New member of Council, Dr. Rotch, of Boston; New members elected were: Dr. J. P. Crozer Griffith, of Philadelphia, and Dr. T. F. Sherman, of Boston.

The Managers of the Children's Seashore House at Atlantic City offer to receive, free of charge, during June, as many bed-ridden or crippled children from the hospitals, public institutions, and private homes of Philadelphia and vicinity, as their

institution will accommodate. Application for the admission of such children should be made in writing to the "Physician in charge of the Children's Seashore House;" until June 1st, at 332 South 15th St., Philadelphia, and after June 1st, Atlantic City, N. J. Railway tickets are sold to patients coming to the institution at reduced rates.

The Calendar of the University of Vienna for the present summer semester contains a list of 226 courses of lectures, demonstrations, and private courses in the Medical Faculty, to be given by 26 ordinary, 31 extraordinary professors, and 78 *privat docenten*. In the winter semester of 1891-92, the total number of students in the Medical Faculty was 3,115, being 51.6 per cent. of the total number of students in all the faculties together. Of the foreign contingent, the United States of America headed the list with 93, Russia coming second, and Germany, Great Britain, and other countries following *longo intervallo*.

It is proposed to establish a club for social purposes, restricted in its membership to members in good standing in the regular profession of medicine, in Philadelphia. A modest club-house is to be secured in a central location, to be fitted up with chess-tables, billiard-tables, etc., where meetings can be held, committees have accommodations, and members may congregate for social intercourse. A reading-room is to be opened where may be kept on file the principal medical journals, the literary magazines and journals of the day. It is contemplated to have occasional (monthly or bi-monthly) dinners, to which non-members of eminence may be invited. The fees and dues are to be moderate, ten dollars initiation at present, and annual dues of ten dollars.—*Medical News.*

Dr. George M. Gould, editor of the *Medical News,* requests us to call attention to his offer of a prize of $100 for the best essay sent him, "setting forth historically and actually, the ridiculous pretensions of modern homœopathic practice." The essay, containing not over 15,000 words, and type-written, must be sent to him on or before January 1, 1893. It must not contain the author's name, but must be accompanied by a sealed letter containing the author's name with a motto or *nom-de plume* (corresponding to the nom-de-plume on the type-written essay?). When the prize has been awarded, the essay will be cheaply but well printed in large quantities, and supplied to physicians at the cost of printing. We have no faith in true homœopathy, and no sympathy with that which falsely displays its banner; yet we hope that the essayist will write with modesty, as there are individual "glass houses" on both sides of the fence.

In an address before the Cambridge Temperance Association, a few weeks ago, Professor Humphry raised his voice against the habit of tippling or nipping—taking a glass now, a glass then, and a glass often; in the morning (which was worst of all), at the mid-day meal, in the afternoon, and in the evening. Even more than drunkenness, he said, this was terribly damaging to the system; it made men sodden, and was evinced in a general shakiness of the hand, sometimes of the step, and above all of the tongue—in fact, a general shakiness of all the organs. The "nippers" succumbed to slight accidents, slight illness, or slight shock of any kind. Prick them, and the life, as it were, ran out of them. They said, "My work is hard," and they took the very means which unfitted them for good and prolonged work. By temperance in drink, he meant that nothing should be taken whatever, under any conditions, except at meals, and very little then. Those who could not be absolutely temperate, and content with moderation, should become total abstainers.—*Brit. Med. Jour.*

MARYLAND MEDICAL JOURNAL.

VOL. XXVII. No. 6. BALTIMORE, JUNE 4, 1892. NO. 584

CONTENTS

ORIGINAL ARTICLES.

On Public Disinfecting Stations and the Use of Steam under Pressure as a Disinfectant. By Eugene F. Cordell, M. D., Baltimore. . . 683

The Value of Electricity in the Treatment of Nervous Diseases. By Geo. J. Preston, M. D., of Baltimore. 688

EDITORIAL.

The Chloride of Silver Dry Cell Battery. . 693

A Thought on Relaxation. 694

REVIEWS, BOOKS AND PAMPHLETS. . . . 694

MEDICAL PROGRESS.

Medical and Chirurgical Faculty.—Strychnia in Snake-Bite.—Retro-Pharyngeal Abscess in Infancy.—The Effect of Persistent Motion.—Canada and Health Reports.—Hæmorrhage Following Tonsillotomy; Ligature of the Common Carotid; Transfusion; Recovery.—Spontaneous Recovery from Gangrene of Intestine.—On the Dangers of Washing out the Stomach.—Operation for Recurring Dislocation of the Lower Jaw. 695

MEDICAL ITEMS. 702

Original Articles.

ON PUBLIC DISINFECTING STATIONS AND THE USE OF STEAM UNDER PRESSURE AS A DISINFECTANT.*

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With the increase in our knowledge of micro-organisms and the accumulating evidences of their wide-spread and baneful influence, there has been a corresponding increase in the attention paid to disinfection and in the realization of its supreme importance. Indeed, it may be said that the prevention and treatment of disease have largely resolved themselves into the discovery of agents which will destroy these insidious and deadly enemies of our health and lives, and yet be harmless to ourselves and not injurious to our property. One of the most important advances made in preventive medicine of recent years has been the passage of the law requiring notification of infectious diseases, and I desire, in passing, to commend the determination evinced by our health commissioner, Dr. McShane, to enforce this law—so essential to the health of our people and to the welfare of this community. By its aid alone can prompt measures be adopted for isolating the sick and disinfecting infected localities and articles.

There is no difference of opinion and none in principle, though details vary, as to the use of disinfectants in rooms which have been occupied by those sick of infectious diseases and for their contents. I have no intention of opening up a discussion of disinfectants generally, and the limits of this brief paper would not permit me to do so. I will only say that a thorough scrubbing of floor and woodwork with soft soap, scraping, if necessary, and white-washing the walls, hot

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white-wash perhaps being preferable to cold, fumigating the room with sulphur and soaking the linen, etc., in disinfectants and then prolonged boiling, are effective measures in proportion to the thoroughness and intelligence with which they are carried out. According to Rubner (who is Koch's successor in the chair of hygiene in the University of Berlin), all germs are destroyed by boiling in water for one-half hour: it requires twenty minutes to destroy the tubercle bacilli, ten minutes for the typhoid bacillus, and simply exposure to boiling water to destroy those of cholera and diphtheria. This must, therefore, be regarded as a mode of disinfection to be preferred whenever it can be employed.

But apart from the element of uncertainty as to thoroughness and the difficulties in the way in attempting to carry out such measures in private apartments, there are articles, such as mattresses, carpets, hangings, heavy clothing, etc., which could not, owing to their bulk, or other causes, be treated by them, or which might be injured by them. This leads us to consider what other measures are available.

Realizing our needs in this direction, most of the German cities (and it is to Germany that we look at this time for leadership in this field) have established central disinfecting stations, where furniture, bedding, etc., are subjected at public cost to the most approved modern methods of disinfection. England and France and other European countries have adopted the same measure, and some of our large cities are awakening to its importance. I deem it quite unnecessary to argue at length in favor of such a service in a city of the size and importance of this, with the authorities wide awake to all the advances in municipal government of the day, provided only the facts are duly appreciated. I shall endeavor briefly to describe what has been learned and done regarding this most important subject.

It has long been known that heat surpasses all other agents as a disinfectant. At first it was supposed that a dry heat equal to that of boiling water would destroy all germs of disease. Then it was found that there were organisms which could withstand even a higher temperature than this—as the spore-bearing organisms, of which the anthrax bacillus was taken as a representative; it not being known at that time that the spores of this organism are exceptionally resistant, and that most other organisms—the tubercular, typhoid, diphtheritic, choleraic, erysipelatous, and others—are far less tenacious of life. Even sulphurous acid, as we have learned, is only effective when applied in connection with steam, and yet this combination is particularly injurious to clothing and other fabrics. Dry heat is likewise injurious and does not penetrate through heavy materials. Steam heat is much less harmful than either and can be applied to the disinfection of most materials, especially if they be first heated to the boiling point by dry heat and dried again subsequently to the steaming. To Koch himself we owe the discovery of the great germicidal power of steam. According to all researches hitherto made, steam under pressure is the ideal disinfectant. No known form of life, either animal or vegetable, can survive a brief exposure to its influence. On this point all authorities are agreed.

What are the essential points, then, to be observed in the construction of a public disinfecting station? Such a station should be centrally and conveniently located, on ground isolated from dwellings and frequented places, and enclosed by a high wall. No other business should be allowed on or near the disinfecting works. The establishment should be under the control and management of the city authorities, or if the service be given out by contract, it should be strictly understood that no other business is to be carried on in connection with it, such as car-

pet cleaning, etc. There should also be frequent and thorough inspection of the premises and procedure by a competent person. Separate vehicles and drivers should be provided for conveying articles from houses to the station; the drivers should be dressed in some distinctive garb, and the vehicles should be stabled to themselves. These vehicles should be air-tight and the articles should be placed in bags and taken through a window to them, not carried through the passage and hall-way. Such articles should be submitted to fumigation before removal from the house. After disinfection they should be returned to the owner by a separate conveyance and they should never be returned to infected apartments. The disinfecting building should be divided into two compartments by a brick partition, into which should be built the steaming chamber or stove. It should have a door of entrance on one side of this partition and a door of exit on the other side, so that materials once disinfected are not by any possibility brought in danger of reinfection.

The heating apparatus employed is usually cylindrical in shape. It is heated by a furnace or by Bunsen burners or gas-jets. The dome should be peaked or angular, so the steam condensing on its roof may run down the sides and not drip on to the clothing, etc. Steam is admitted by means of a pipe. It should always be introduced at the top of the stove and allowed to escape from the bottom into the opposite apartment. This downward current against gravity is considered very important, because the steam thus finds its way into every crevice and nook of the stove, which it might not do if it came in at the bottom and escaped at the top. The apparatus should be air-tight and should be lined inside with asbestos to avoid injury from contact of linen, etc., with the metal sides. The articles to be disinfected should lie on frames in the centre, or be hung up. Musty bedding and old clothes should not be introduced with new articles and fine linens, as the smell of the former, which is not destroyed by heat, will be communicated to the latter and remain attached to them for a long time.

Having introduced the articles to be disinfected, the temperature of the chamber is raised to the boiling point (212° F.), so that the steam shall not condense on cold surfaces. The steam is then let in and continuously applied for a period of twenty minutes, which is long enough for ordinary purposes, or for thirty minutes at the maximum. The time element is of great importance because too long an exposure will injure certain materials. The temperature is assured by means of a thermometer, placed inside the bundle of clothing, etc., and communicating with a battery on the outside; by a simple device a bell may be made to ring when the desired temperature is reached; or a thermometer may be placed in the tube by which the steam escapes. V. Budde (*Zeitschrift für Hygiene*, Band VII, p. 269) deprecates excessive heating of the steam, as that interferes with condensation, which permits the powerful effect of the latent heat to be brought to bear upon the materials. Excessive heat is also objectionable, as stated above, on account of the possible injury to the articles. There is some difference of views as to the degree of pressure to which the steam should be subjected. Some of the most approved apparatus used allows of a pressure as high as 25 pounds to the square inch. The London *Lancet*, in the "Report of its Special Sanitary Commission on Disinfecting in London," January, 1891, refers with strong approval to the establishment of Mr. W. G. Lacy, formerly medical assistant at a London fever hospital, who disinfects for a large part of the city of London and for a great number of private houses, schools, etc., within a radius of twenty or more miles around London. The stove here employed is of great strength and the huge, thick, heavy door, which is screwed down, bulges out

under the force of the high pressure. There is a safety-valve to prevent explosions. Even exposure to this tremendous pressure is not considered sufficient by Mr. Lacy, since it only compresses the air in the thickness of mattresses, etc., and the moist heat will not penetrate these bubbles of compressed air. To break up these bubbles they are made to expand rapidly by letting off some of the steam and then turning on again more steam. This is the most powerful process of disinfecting known, for whereas dry heat and sulphurous acid, whether dry or moist, exert only a superficial effect, steam under high pressure will penetrate the heaviest mattresses and even more compact substances. Scientific experiments have shown that germs placed in the centre of a thick mattress are killed in fifteen minutes by it (*Lancet*, loc. cit.). Into such an apparatus it is not necessary to introduce separate articles, to open mattresses, etc.; the articles are put in canvas bags before being taken out of the infected room and introduced into the oven without unpacking. In consequence, a greater number of articles can be disinfected each time and the process is conducted with great rapidity. The stove of Mr. Lacy is exceptionally large, having a capacity of five cwt. The degree of pressure is determined by a simple manometer. Many consider that a pressure much below the above is sufficient—say two pounds to the inch. The President of this Society, Prof. Welch, tells me he is of this opinion, and in view of the great expense and risk connected with the high pressure apparatus, this opinion is entitled to careful consideration.

Mr. Lacy has also a stove for articles not requiring penetration, or susceptible to injury, as boots, books, mantel-piece ornaments, spring-mattresses, etc., and for articles that can be spread out so as to expose all their contents.

It cannot be denied that the establishment of such an institution involves great expense and requires a large force of specially trained employees; moreover, to conduct it requires a man of scientific qualifications—it certainly will not fulfill the purpose desired if entrusted to an ignorant or untrained person. Its advantages are incalculable, and when we contemplate it in the light of modern knowledge and discovery it becomes simply a necessity. Certainly, should an epidemic arise in our midst—at any time a possibility—we should be in but a poor plight without it.

One important point is to be constantly borne in mind in order to make this or any other mode of public disinfection feasible, and that is, that the materials must be returned to their owners uninjured. Nothing will deter people from sending their clothes, etc., to be disinfected so much as to have them once sent back in a damaged condition. Some discrimination is necessary, therefore, in deciding what articles can be subjected to steaming; leather, stamped plush, skins and water-proof materials cannot; linen or similar materials will be iron-moulded if brought in contact with iron; grease should be removed beforehand, if possible, otherwise it becomes fluid and is liable to spread; blood and pus are coagulated and can be afterwards removed by chlorine or other solvents. According to Levison, fast-dyed materials are not injured. A lady's seal-skin jacket is not damaged by 240° F. Intermittent heating below 212° F. is advised for kid gloves. Other details regarding this part of the subject are given by Levison (*Zeitschrift für Hygiene*, Band VI, p. 225). Finally, the suggestion has been made and it carries with it its own recommendation—that there should be some place provided where poor people may go whilst their houses and clothing are being disinfected.

It may be well, in concluding, to consider what is being done in other cities, especially of our own country.

In Boston, in "scarlet fever and diphtheria," reliance is placed upon burning sulphur; nothing is said of other diseases. There is a building at the quarantine station where steam disinfection is practised. I have not learned further details.

In New York, disinfection is practised by dry sulphur fumigation; beds, pillows, mattresses, upholstered furniture, etc., being cut open and contents spread out. Bedding or other removable articles are taken to the disinfecting depot on East River, where they are "thoroughly disinfected by hot air or steam, in an elaborate apparatus, especially constructed for that purpose."

In Washington City, the room where a patient has been ill with scarlet fever or diphtheria is thoroughly disinfected by exposure for several hours to the fumes of chlorine gas, or of burning sulphur. All clothing, bedding, carpets and other textiles which have been exposed to the contagion are required to be either burned, exposed to super-heated steam, or thoroughly boiled.

Fumigation with sulphur is practised, and it is stated that "the owners of a private establishment for the renovation of carpets, bedding and other textiles, have constructed, in an isolated place in the District, a separate tank for the cleansing of articles that have been exposed to infection, by super-heated steam and naphtha."

At the quarantine stations in Charleston and New Orleans, steam heat is employed and the methods and apparatus seem to be very thorough.

In London the methods vary; the city authorities prefer sulphur fumigation, but the use of steam-disinfection is growing and the large stove of Mr. Lacy above mentioned "disinfected for one district alone more than nine tons of articles during the Christmas quarter." The district of St. Pancras has built for its use a stove which is an exact copy of Mr. Lacy's. A number of districts employ Lyons' steam pressure stove, which is much smaller, so that two are sometimes required.

In Germany, there is more uniformity in practice, and the principles which I have endeavored to explain and recommend are there carried out with the highest degree of efficiency. A useful addition to the so-called refuges in Berlin is the bath which can be taken by persons whilst waiting to have their clothing disinfected in the adjoining steam-chamber. In Cologne, for economic reasons and to give employment to stokers and others temporarily out of work, the apparatus is connected with the steam laundry of the city hospital. The Schimmel apparatus seems to be very popular in Germany.

In Paris there are three public disinfecting ovens, and the service is carried on with all the precautions I have narrated above.

Moscow as yet has only a sulphur fumigating establishment. I might give further details collected in my investigation of the subject did time permit.

In this city the measures pursued for disinfecting apartments and their contents correspond with those usually employed, but in a circular entitled "Suggestions for Preventing the Spread of Scarlet Fever," issued by the Board of Health, I find the following: "Most articles may be disinfected in a room if hung up loosely and exposed to the fumes of sulphur, although it would be an additional safeguard to expose anything thick, like a bed-mattress, to prolonged heat at a temperature of about 240° F: and indeed, *heat* or steam must, with our present knowledge, be considered *the best disinfectant.*" (Italics in original.) That our present efficient Health Commissioner is alive to the importance of the considerations which I have urged above, appears from the fact that last fall he secured permission from the city authorities for the erection of a frame building for fumigation. This building adjoins the morgue and is under charge of the keeper of the morgue. It consists of

two layers of boarding filled in between by four inches of saw-dust, so as to be as air-tight as possible, and has a capacity sufficient to admit a hack. About three pounds of sulphur are used for each thousand cubic feet of space. It has been in operation now since about the middle of November and a large quantity of bedding and bed-clothes have been disinfected there. Twelve to fourteen hours are deemed sufficient time for exposure of the articles to the sulphur fumes. While from the facts presented above this arrangement cannot be considered sufficient, it is a step in the right direction and will doubtless lead in no great while to more efficient methods.

WORKS CONSULTED.

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THE VALUE OF ELECTRICITY IN THE TREATMENT OF NERVOUS DISEASES.*

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There exists the greatest diversity of opinion concerning the value of electricity in the treatment of disease. Extolled to the skies by some, and used in almost every imaginable complaint, it is by others condemned as utterly worthless—a medical toy or humbug. In a paper recently read by one of the pioneers in electro-therapeutics in this country, the author, Dr. Rockwell, relates a number of very amusing anecdotes which show well the attitude of the profession towards electricity twenty-five years or more ago. He was told by many of the most eminent and advanced men in the profession in New York, that if he attempted to advance the claims of electricity as a therapeutic agent he would lose his professional standing, and it was with a great deal of trepidation that he began his great work. After a good many years of patient and persistent work, carried on by a few enthusiastic men, the value of electricity became recognized, and as in the case of many new therapeutic agents, the pendulum swung too far.

The praises of electricity have been loudly sung by its advocates, and claims made for it which perhaps cannot be entirely substantiated. One thing which makes it very hard to place a just estimate on the value of electricity is the fact that many of the symptoms which are treated by electricity are subjective—pain for example—and it is difficult to discount the effect of the mental impression. The subject of electricity from the standpoint of physics was for so long such an obscure one, and the medical application of it even now is so imperfect and little understood, that people were willing to believe any statement that might be made regarding it. Then the quacks seized upon it with such avidity, as being an agent just to their hand, that the medical man who uses electricity scientifically is placed between the horns of a dilemma; the laity willing to believe anything about this mystic power, the profession at large decidedly sceptical and leaning to the opinion that it is a humbug.

The object of this paper is to assign, if possible, a proper place to this agent

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in our therapeutic list. The conclusions are drawn from the results obtained in the electrical clinic at the College of Physicians and Surgeons and from private practice. The work has been done in a fairly accurate manner, and the results noted at the time, so that there are pretty full records of all cases. The notes made include the diagnosis of the case with a brief history, the number of applications made, the length of time of such applications, the number of cells used and the number of milliamperes as registered by our meter.

The results obtained in cases of organic cord disease, omitting atrophic diseases, have been almost nil. Spastic conditions are perhaps made worse, or at least not the slightest improvement has been noted. In some cases of locomotor ataxia, the pains have been decidedly lessened, and the stiffness in the joints helped.

In regard to organic disease of the brain, omitting hæmorrhage, in the few cases that were treated no results were obtained. A number of cases of hemiplegia, in various stages, have been treated, not with any idea of influencing the hæmorrhage, but with the view of furnishing nutrition to the muscles and thus preventing the disabling contractions. Cases of hemiplegia are, as a rule, sadly neglected, and a certain amount of care will often preserve or even restore valuable movement to paralyzed parts. In addition, of course, to massage, the muscles should be stimulated to vigorous contractions, thus aiding in their nutrition and preventing to a certain degree shortening and contractions. The faradic current answers this purpose best. In the atrophic diseases referred to, electricity is unquestionably of distinct service. The type of the class of cases in which the good results of electricity are most apparent is acute polio-myelitis. In the early stages weak galvanic currents must be employed; later, stronger galvanic and faradic. It is surprising how much can be accomplished in some of the old cases of this disease, or rather in the resulting atrophies. The statement is usually made that when a group of muscles has gone on atrophying for many months with marked reaction of degeneration, there is no hope for any gain in power. Of course we cannot hope for anything like good use of the atrophied muscles after the period of repair following the acute attack has passed, but we can often obtain a decided amount of movement, for which such patients are very grateful. For example: Kate B. had marked atrophy of deltoid and scapular muscles, dating from infancy, of perhaps eight years' duration. In the year or more that she has been under treatment, she has improved very decidedly, and has gained a very useful amount of movement. This case had been entirely stationary for years, and if the improvement continues in the same ratio, she will have a useful limb. Fred M., infantile hemiplegia of several years' standing, with impeded growth and contractions; came to Dispensary for three months once or twice a week, and in that time there was a decided gain in the nutrition and use of paralyzed limbs. In cases of this kind, both galvanic and faradic currents are employed, stimulating the nerve supplying the paralyzed muscles, and also stimulating the muscles directly. The great difficulty is to get these patients to attend regularly. They are very apt to become discouraged at the slow improvement after a few months and discontinue their visits. Cases of progressive muscular atrophy and cases of myelitis involving the gray matter are not benefited to any appreciable extent. There have not been enough such cases, however, treated systematically in our clinic to warrant any conclusion.

It is in the case of peripheral nerve lesions that we see the most striking good effects of the electrical treatment. It seems to me that while organic cord lesions are rather less frequent in Baltimore than in some other cities, peripheral

nerve lesions are more frequent, and abundant opportunity has been afforded to test the value of electricity in these cases.

It has happened a number of times that cases of the same nature would present themselves, one coming regularly for treatment, the other not reporting for weeks at a time, and the difference has been most apparent.

A large number of cases of multiple neuritis have been treated with the most gratifying results. There can be no reasonable doubt, I think, that electricity greatly hastens the cure of these cases. The applications are rather tedious, since the number of motor points to be gone over is large, and it is necessary to devote a good deal of time to each case. Moderate galvanic currents, 15 to 20 M.A., are employed, one pole, the positive, at some indifferent point, and the other over the motor points. In the case of local neuritis, the effects of treatment are often still more marked. Jos. R., injury to facial nerve; after six applications of 20 M. A., was nearly entirely cured. Mat. D., pressure paralysis, complete of right arm; entirely cured by eight applications of 20 M. A. John F., pressure paralysis of right arm; a few applications of 35 M. A. brought about cure. A number of cases of idiopathic facial paralysis have been treated, with varying results. In a few instances the relief has been remarkably rapid and the cure complete. In other cases there has been gradual recovery, and in some cases no improvement. It is often very remarkable how cases of general or local neuritis of long standing, that have never had electrical treatment, will improve when this is begun. Mrs. J. had a general neuritis more than a year before her appearance at the clinic. When first seen her hands were claw-shaped and practically useless. After two or three months' treatment, she was able to do her ordinary work fairly well. Many cases illustrative of this point could be related from our records.

The value of electricity in the treatment of neuralgic pains is very marked, and yet we cannot say beforehand what sort of cases are going to be relieved. As yet we have not been able to classify these cases with any degree of satisfaction. Certain cases of neuralgia, trifacial, brachial, intercostal, etc., are relieved by a single application, while cases apparently exactly similar receive no benefit. The difference must, of course, reside in the underlying cause of the neuralgia. In these cases of neuralgia the galvanic current is used, with the positive pole over the sensitive spot, the negative at some indifferent point. I think moderately strong currents are the best; 20 to 30 M. A., or even stronger, if the patient will tolerate them, continued for ten to fifteen minutes, or longer, and applied every day or twice a day.

Many of the functional diseases of the nervous system are distinctly improved by the electric treatment. Cases of chorea, especially those that resist medicinal treatment, can be relieved in this way. Of course in this disease we must give due weight to the strong mental impression that is made upon the child's mind by the battery. This latter point is also a very important factor in the treatment of hysterical patients by electricity. Undoubtedly many of the drugs that are so popular in the treatment of hysterical conditions, notably valerian and assafœtida, owe part, if not all, of their efficacy to the strong odor which they possess, and the consequent mental impression that is produced. So in like manner electricity produces a very strong impression on the mind of the hysterical subject, which is an important and necessary element in the treatment of such cases. All forms of electricity may be used in the treatment of these last two affections, the most reliable being the faradic current. The interrupted galvanic is almost equally good, and much may be said in favor of static electricity, since the para-

phernalia employed in its production and the spark drawn from the patient are well calculated to produce the desired impression.

To consider the use of electricity in neurasthenia and allied conditions of nervous exhaustion would lead us too far into the general effect of this agent upon the vaso-motor system, the muscular system, the peristaltic action of the intestines, etc. Suffice it to say that electricity, in such affections, is the only therapeutic agent, except hydrotherapy, of any value, and combined with rest, exercise, and forced feeding, it constitutes the routine treatment.

One condition, which though not included under the heading of this paper, deserves mention in any discussion of the general value of electro-therapeutics, is chronic rheumatism. The pain and stiffness of the joints is often very much relieved, and more good done than by any other means unless it be massage, which acts in much the same way. I have had constructed in my office battery a switch designed by de Watteville, by means of which both galvanic and faradic currents pass to the same electrodes, and I prefer it to either current alone in the treatment of these cases. The above brief resumé expresses pretty accurately, I think, the conclusions which the practical results of the past few years of electrical work would warrant. It was intended merely to give general conclusions and not to dwell on details or to report cases. In conclusion, I would point out two reasons why, in my own opinion, the general practitioner fails often to get the desired results in electrical treatment. In the first place, the requisite amount of persistence is wanting both in doctor and patient. The benefit accruing from this method of treatment comes with provoking and discouraging slowness. An agent like electricity, from the nature of the case, must in many instances accomplish its results very gradually. Corresponding as it does so closely to the normal nerve stimulus, it simply replaces this normal stimulus when it is wanting. In the case of disease of the peripheral nervous system, the normal stimulus can no longer pass along the diseased nerves, and the artificial stimulus keeps the nerve to a certain extent in a condition to convey impressions—keeps it functionally active. One should no more expect to get sudden results from electricity than from systematic exercise or massage. In many cases the actions are similar. In certain painful conditions, it is true, we get rapid, sometimes almost instantaneous, good results, but these are purely functional conditions, and the electrical stimulus simply restores a deranged function. Of course, what is said here in regard to the rationale of the action of electricity is mere speculation, and all speculation concerning this complicated subject is more or less idle. The fact remains, however, that to get any good results from electricity in most cases it must be persistently used like any other tonic. This, I am sure from experience, is one of the reasons that failure rather than success so often attends this mode of treatment. The second reason for failure is the neglect in measuring the amount of electricity used. It very often happens that the electrodes are not sufficiently moistened, or the connections imperfect, and while the patient may experience a good deal of pain, the actual current passing may be very small. There is no question of the fact that the dose of electricity must be measured as other doses are. The resistance of the patient's body varies enormously under different conditions, so that the number of cells used is a very untrustworthy guide. Especially is this true when we are using strong currents. Unfortunately the meters for measuring the currents are more or less expensive, require some knowledge and skill to keep them in order, and are not always reliable. Still, in spite of these drawbacks it is absolutely necessary to employ some means of measuring the current other than the number of cells in circuit. If, then, these two

points, the patient and persistent application of the current, and some reliable means of measuring it, be observed, it is certain that much better results will follow the use of electricity than is generally the case.

The limits of this paper do not permit any discussion of the important details connected with the proper application of the electric current nor any mention of apparatus. At a future date, if the Society permit, the subject of electrolysis and the results of the use of electricity in gynæcology will be presented. This latter subject has attracted so much attention of late years that the general use of electricity in nervous diseases has rather been lost sight of, and it was thought that perhaps it might be of some service to call attention to it, and try, if possible, to ascertain its value.

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CASE OF HAIRPIN IN THE FEMALE BLADDER.

On January 24th I was summoned to a young lady, whom I found to be suffering great pain over the region of the bladder. She told me she had been troubled for a long time with irritation about the orifice of the urethra, which she relieved by rubbing the part with the rounded end of a hairpin; and that while in bed that morning the pin had slipped from her fingers. She did not mention the circumstance to anyone, but got up and went about her duties as usual, though suffering intensely; till, being unable to bear the pain any longer, I was sent for about 4 P. M.

Upon examination, I felt the pin in the bladder distinctly, but after trying for an hour I was unable to seize the ends with forceps. I then introduced a large-sized sea-tangle tent into the urethra, which well dilated it, and attempted to get hold of the pin with a larger pair of forceps; failing in which I tried also with a hook unsuccessfully. Chloroform was administered, and I was able to introduce my finger into the bladder without doing much damage to the urethra, when I felt the pin lying obliquely in the bladder, the points sticking into the mucous membrane. Upon freeing these it was possible, by pressing them together, to remove the source of the trouble without the aid of a contracting bladder. She had a very acute attack of cystitis, with purulent discharge, which, however, got well quickly under ordinary treatment. There was some incontinence of urine for a period, but she soon recovered perfect control, and made a good recovery.

Such an accident, I am well aware, is not of rare occurrence; but it is one which, when it does take place, not unusually gives the surgeon a great deal of trouble. Some authorities recommend sudden rupture rather than gradual dilatation of the urethra: but in this case the results of the latter were most satisfactory, and should I have another case of the kind to deal with, I would certainly resort to gradual dilatation and manipulation with the finger, without the use of any instruments.—Dr. Stamford, in *Brit. Med. Jour.*, May 14, 1892.

Dr. J. J. Crow, of Carrollton, Ill., writes: "I have lately used common flour burned in a stove-pan as a dressing for erysipelas, senile gangrene and burns, and am much pleased with it. It is almost everywhere present, and may be prepared in a few minutes. It is cheap and may be impregnated with iodoform, aristol, or other antiseptics. I hope the profession will give it a fair trial. It is, of course, finely divided charcoal.—*Med. Rec.*

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Editorial.

THE CHLORIDE OF SILVER DRY CELL BATTERY.

The introduction of this form of constant current electric battery for use by practitioners is in our opinion one of the most desirable advances of recent years. While the specialist may find his stationary office batteries all that need be desired, the general practitioner will welcome the invention of a battery which may be conveniently carried about either in the buggy or by hand.

The chloride of silver battery is furnished in such compact form that one of fifty cells can be easily carried in the hand.

It is claimed that this fifty-cell galvanic battery will furnish a current as strong as is needed for ordinary purposes. It is always dry and clean, having no liquid to spill over its case or over the carriage floor. Another virtue which it possesses is that it is always ready to do its work on a moment's notice, without any manipulations except the attachment of the electrodes.

Our experience with it is limited to electrolytic work upon the skin, to the treatment of neuralgias and myalgias, and to the cataphoretic application of drugs. In such service we have found the battery always ready to do its work promptly, evenly and efficiently. For the destruction of hairs, warts, etc., a current of ten or twelve cells is sufficient—provided the sponge electrodes be kept free from grease by occasionally washing them with soap and water.

In the treatment of spinal paralyses or the destruction of large tumors we have as yet not tested it.

As might be expected, the chloride of silver cell is especially well suited for the generation of the primary current of a faradic battery. Such batteries are in the market. The insertion of a metal pin sets them at once to running. The quality of work done by the faradic battery depends of course on the excellence of the coil rather than on the cell which generates the primary current.

Although the cost of these batteries is high, they do not get out of order, and

the expense of refilling the cells is not great. For ordinary uses the cells will last several years without any expense in repairing or refilling.

A THOUGHT ON RELAXATION.

A short afternoon excursion to Round Bay, half an hour by rail from the city, reminds us that all of life is not to be found in the treadmill of daily practice.

The physician who lets the glorious and mind-bracing beauty with which the advent of the summer clothes the country-side pass unheeded year after year, and never slackens his medical labors to revel in the freshness of the leafing forest, the tinting of the woodland flower, or the perfume of the new-mown meadow, is guilty of the murder of some of the noblest faculties of his soul.

City men are prone to deceive themselves with the thought that it is their duty to devote every hour of the day, from Monday morn to Saturday eve, and from January to December, to their business. A little reflection shows, however, that this is not a real necessity, if one is content with reasonable success. The hard-worked practitioner should be among the first to recognize the opportunities offered him in the opening by our railroads of pleasant and easily accessible country-side and water-side resorts, where he may, in a single afternoon, obtain sufficient recreation to relax his tetanized involuntary muscles, and start his torpid secretions, to quicken his step and clear and tone his mind, for weeks to come.

Reviews, Books and Pamphlets.

A Dictionary of Treatment; or Therapeutic Index; Including Medical and Surgical Therapeutics. By Wm. Whitla, M. D., Professor of Materia Medica and Therapeutics in the Queen's College, Belfast, etc. Revised and adapted to the pharmacopœia of the United States. Philadelphia: Lea Bros. & Co., 1892.

This volume of 900 pages has grown out of the effort of the author to furnish a complete therapeutic index to accompany his work on Materia Medica and Therapeutics, which is now in its *fifth* edition.

The Year-Book of Treatment for 1892. A Critical Review for Practitioners of Medicine and Surgery. In one square 8vo. volume of 491 pages. Cloth, $1.50. Philadelphia: Lea Bros. & Co., 1892.

Contains short abstracts of important papers which have appeared during the year, prepared in each department by well-known physicians and surgeons of Great Britain. A list of medical books which have been published is appended.

Lectures on Tumors, from a Clinical Standpoint. By John B. Hamilton, M. D., LL.D., Professor of Principles of Surgery and Clinical Surgery, Rush Medical College, Chicago; Professor of Surgery, Chicago Polyclinic; Surgeon, formerly Supervising Surgeon-General, U. S. Marine Hospital Service, etc. For the use of students. 2nd Edition. Pp. 142. In cloth, 50 cts. Geo. S. Davis, Detroit, Mich., 1892.

The author presents in this little volume the substance of a course of lectures delivered to his medical pupils in the Georgetown University. He is urged to

the publication by the belief that no single English treatise brings together the varieties of tumors set forth in our present nomenclature, giving the symptomatology and treatment.

A Text Book of Nursing; For the Use of Training Schools, Families and Private Students. Compiled by CLARA S. WEEKS-SHAW. Second Edition, Revised and Enlarged, with Illustrations. New York: D. Appleton & Co., 1892. $1.75.

We welcome the second edition of this valuable little book, the first edition of which, a favorite text-book in training schools for nurses, made Miss Clara Week's name familiar in so many households. The present edition contains not only a revision of old matter but the addition of numerous details rendered necessary by recent advances in medicine, and especially in general and gynæcological surgery. After a rapid and appreciative perusal, the only injunction which we feel inclined to dispute is that in *ophthalmia neonatorum* if the eyes "do not show improvement promptly, the granulations should be touched with a solution of nitrate of silver, gr. xl–℥j." The use of a solution of nitrate of silver, 40 grains to the ounce, by a nurse, would be extremely dangerous. Even in the hands of a physician, a single drop of a solution, 5 or 10 grains to the ounce, is as much as the eye will bear, and suffices for therapeutic ends. Perhaps the figures are a type-setter's mistake. The work as a whole is excellent.

Medical Progress.

MEDICAL AND CHIRURGICAL FACULTY, 1892-93.

THE "SECTIONS."

Surgery: Randolph Winslow, J. T. M. Finney, Charles F. Bevan, Jas. Brown, Ridgely B. Warfield. Practice: Charles O'Donovan, Wm. F. Lockwood, J. D. Iglehart, Charles M. Ellis, A. S. Porter. Obstetrics and Gynæcology: J. Whitridge Williams, Wilmer Brinton, H. A. Kelly, W. A. B. Sellman, B. W. Goldsborough. Materia Medica and Chemistry: A. K. Bond, R. H. P. Ellis, A. C. Pole, R. B. Morrison, Edward Anderson. Sanitary Science: James F. McShane, John D. Blake, A. H. Chapman, Wm. B. Canfield, C. Birnie. Anatomy, Physiology and Pathology: J. M. Craighill, James G. Wiltshire, I. R. Trimble, Chas. W. Mitchell, O. H. W. Ragan. Psychology and Medical Jurisprudence: Henry J. Berkley, George J. Preston, Henry M. Thomas, A. L. Hodgdon, B. D. Evans. Microscopy, Medical Chemistry and Spectral Analysis: C. O. Miller, A. G. Hoen, David Streett, Simon Flexner, Wm. T. Howard, Jr. Ophthalmology, Otology and Laryngology: Harry Friedenwald, Samuel Johnston, Herbert Harlan, Frank M. Chisolm, John R. Winslow.

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STRYCHNIA IN SNAKE-BITE.

Dr. Wolfgang Hunt, of the Toowoomba Hospital, Queensland, gives an interesting account in the *Australasia Medical Gazette* of a case which had come under his care. The patient was a child aged sixteen months. An elder sister, while playing with her a little way from home, heard her scream, and saw a snake clinging to her hand. Running to the house she quickly fetched her mother and an uncle, who found the child crying and holding the third finger of the left hand, on which was a small punctured wound. The snake was killed as it was making off, and found to be a "death adder." The child was taken to the house, and the end of the finger removed, the stump being sucked and drenched with ammonia, and ligatures applied to the arm. She was then brought to Toowoomba for the nearest medical aid, ammonia being applied to the hand in the meantime. An attempt was made to give stimulants by the mouth, but vomiting immediately followed their administration. On admission to the hospital, three hours after the accident, the child was almost comatose, the body and extremities cold, pupils dilated and insensitive to light, the pulse rapid and irregular. The child was at once wrapped in hot flannels and heat applied to the limbs, while four minims of liquor strychniæ, one per cent. solution, were administered hypodermically, and a strong faradic current applied to the nape of the neck and along the spine. Fifteen minutes later another four minims of liquor strychniæ were injected, and almost at once a change began to manifest itself in all the symptoms and in a short time the child recognized and played with its parents. With the exception of a few slight muscular twitchings recovery was uninterrupted, and the child was discharged the next day in apparently perfect health and none the worse, except for the loss of her finger. The case is very important, especially with reference to the means used for procuring recovery—viz., the hypodermic injection of strychnia, and Dr. Hunt is to be congratulated on his success in this case, as well as in that of another patient whom he mentions as having been admitted in a similar condition after being bitten by a brown snake, and in whom also recovery followed the hypodermic injection of strychnia.—*Lancet.*

RETRO-PHARYNGEAL ABSCESS IN INFANCY.

Writing at some length upon this interesting subject in the *Lancet* (February 13, 1892), Dr. Pollard, of University College Hospital, London says:

Retro-pharyngeal abscesses were formerly considered to depend invariably on spinal caries. There is no doubt, however, that this was a mistaken view. The majority of cases occur in quite young children, and in them the pus collects in the cellular tissue between the pharynx and the fascia covering the prevertebral muscles; whilst the tubercular abscesses, which depend on spinal caries, are situated beneath the fascia and ligaments, in close contact with the vertebræ. The relative frequency of the two classes of retro-pharyngeal abscess has been pointed out by Bokai, who collected the records of 204 cases which had been observed at the Children's Hospital in Pesth during a period of twenty-six years. Only seven cases in this large total were dependent on spinal caries, whilst as many as 189 were of a purely local nature. Judging by the few recorded cases, from the little that is said on the subject in surgical text-books, from my own personal experience and from that of the medical friends whom I have consulted, I am led to think that retro-pharyngeal abscess is a comparatively rare affection in London. At the North-Eastern Hospital for Children, where the number of out-patients (new cases) in the year has ranged between 13,000 and 15,000, I have only met, during the last five years, with three cases, two of which were under my own care and one under the care of my colleague, Mr. Dean. All three cases were acute and had no connection whatever with spinal caries. Although not a common disease, acute retro-pharyngeal abscess of infancy merits a wider recognition than it appears to have obtained, for it not only gives rise to serious symptoms at all times; but it may, by bursting suddenly, especially during sleep, cause death by suffocation; although the condition is one which, if detected, may be completely relieved by a simple enough operation. The following four cases derive additional interest from the manner in which, notwithstanding the small size and the tender age of the patients, they were treated. (Reports omitted.)

The disease may come on either very acutely or somewhat insidiously. If the abscess is situated behind the upper part of the pharynx, deglutition will be chiefly embarrassed; but if it be situated lower down, respiration will be also impeded. The difficulty in breathing is especially noticeable during sleep, when, too, it may be accompanied by snoring. The voice, as in one of my cases, may be hoarse, owing to associated laryngeal catarrh. The lymphatic glands on one or both sides of the neck are generally swollen. These symptoms are sufficiently suggestive to lead to an examination of the throat, when if there is a retro-pharyngeal abscess, a soft and fluctuating swelling, situated usually rather to one side of the middle line, and bulging the posterior wall of the pharynx forwards, may be felt.

As soon as a retro-pharyngeal abscess is diagnosed steps should be taken to open it, lest urgent dyspnœa come on (as it happened in one of the cases recorded in this paper), or in case the abscess burst when the child is asleep or when assistance is not at hand, and the matter be sucked into the larynx and cause suffocation. There are two possible methods of opening the abscess. It may be opened by an incision through the pharyngeal wall or by an external incision in the neck. The first plan is no doubt the most enticing, owing to the ease with which it can be carried out, but it is not free from objection. The abscess cavity cannot be drained with a tube when the opening is into the pharynx, and consequently the incision may close too soon and the pus may reaccumulate. This occurred in my first case; and, indeed, it was this repeated reaccumulation which led me to dissect down from the outside, after the plan recommended by Professor Chiene, notwithstanding the small size and tender age of the patient. Again, proper antiseptic treatment is impossible when the abscess has been opened in

the pharynx. If, however, this plan is adopted, the child should be put under the influence of chloroform, the mouth should be gagged open, and the head should hang rather over the end of the table. The abscess should then be opened by longitudinal incision reaching the entire length of the swelling, and the pus should be rapidly sponged away, so as to prevent any of it finding its way into the larynx.

Professor Chiene's plan of opening chronic retro pharyngeal abscesses dependent on spinal caries is well known; but I am not aware that it has been adopted for the acute abscesses occurring in infancy, unless the pus was pointing externally. There, is however, no difficulty in performing the operation even when the abscess is small and confined to the retro-pharyngeal tissue, and when the patient is quite a young child. In my first case the abscess was not only strictly retro-pharyngeal, but it had been partly drained into the pharynx, and the child was only seven months old. The operation was done as follows in all the cases. An incision, about an inch in length, and about an inch below the mastoid process, was made along the posterior border of the sterno-mastoid. After the fascia covering the muscles in the floor of the posterior triangle was exposed, a cautious dissection with blunt instruments was made behind the deep vessels and nerves of the neck until one finger placed in the wound almost met another placed in the pharynx. A director, guided by the finger in the pharynx, was then thrust into the abscess, and the opening enlarged by passing a pair of dressing forceps into it and forcibly separating the blades. A drainage-tube should be inserted, and care should be taken that it does not slip out of the abscess cavity, as happened in one of my cases, and give rise to reaccumulation of pus.

THE EFFECT OF PERSISTENT MOTION.

Dr. John Ridlon exhibited at the New York Academy of Medicine a girl nine years old, who had come to him at the Vanderbilt Clinic on April 23, 1891. Eight months previously she had received an injury to the right elbow, which was diagnosticated as a "fracture of the coronoid process of the ulna, and a dislocation backwards of the radius and ulna." She was attended by a well-qualified practitioner of this city. The arm was immobilized for about four weeks, and then passive motion was commenced. Twice daily the forearm was flexed and extended on the arm to the limits of tolerance, and twice weekly, under an anæsthetic, the forearm was flexed and extended to the normal limits of motion. This treatment was faithfully continued for seven months, during which time the range of motion gradually became more restricted, the joint more and more swollen, and more painful under the attempts at motion. Examination showed the forearm flexed on the arm to a right angle, much swelling about the joint, enlargement of the superficial veins, and atrophy of the muscles of the arm and forearm. The swelling had a pulpy feeling, but no point of fluctuation could be detected. The bony points were so obscured that the exact nature of the injury could not be determined. There was no motion of the joint, and attempts at motion caused pain and developed intense muscular spasm.

The treatment adopted was as follows: The head was bent down, and the wrist put in a "halter" made out of a roller bandage, knotted around the wrist and neck. The slack of this was taken up as the rigidity yielded, and at the end of two weeks the joint could be completely flexed. In this position, the joint was held without motion being once permitted or tested for eleven months. The pain disappeared, the swelling gradually subsided, and, when the halter was removed, there was found to be free, painless motion, from a right angle to normal flexion. Since then there has been no treatment, and the range of motion in the

direction of extension is gradually increasing.—(*Buffalo Medical and Surgical Journal*, June, 1892.)

CANADA AND HEALTH REPORTS.

Our northern brethren do not propose to serve the government for nothing; as is seen by the following extract from the *Montreal Medical Journal*:

When an effort is made, as it may be, to obtain a fair recorded return from the medical practitioners of Canada of the general condition of the public health, especially as relating to infectious or malarial diseases in their respective localities, hundreds will doubtless cheerfully respond to the calls of science and the public weal. When the work has been done for a time and the value of it has been manifested, proper representation of it to the government and the people will doubtless bring the reward. The great majority of the masses of the people prefer to pay fair, full value for all or anything they receive from their fellowmen; although it may not be always easy to get them fully awakened to an appreciation of the value of some services.

There are always a number of able "medical members" in the Parliament of Canada who look to the interests of the profession, and the profession may be sure that so soon as the public will sanction a vote of money to remunerate physicians for such public service as making returns of sickness for the public good—in the cause of the public health, such vote will be urged upon the Government by the medical members and asked for in the estimates by the Government.

HÆMORRHAGE FOLLOWING TONSILLOTOMY; LIGATURE OF THE COMMON CAROTID: TRANSFUSION: RECOVERY.

Mr. Arbuthnot Lane related the case of a man, aged 21, who had his tonsil removed at the Throat Hospital on December 16th. At the time of the operation and during the few hours following he lost about half a pint of blood; on December 19th he lost another half pint; bleeding recurred on the 20th, and continued steadily in spite of local applications. On December 22nd, as he was evidently dying, his friends consented to his removal into Guy's Hospital, a distance of only a few yards, and he was carried directly into the operating theatre from his house on a stretcher. Normal salt solution had to be introduced freely into the circulation before any other operation could be done. He reacted at once to the injection; when Mr. Lane tied the common carotid. It was not necessary to inject more than 3½ or 4 pints of salt solution, his pulse being then 96, large and full. He left the hospital within a few days quite well. The point of interest about the case, besides the perfectly successful result of the saline intravenous injection, was the delayed onset of the bleeding, which recurred more than four whole days after the excision of the tonsil.

On examining the excised area after the operation, as the patient's condition did not admit of it before, no evidence of any injured vessel could be seen. The tonsil had been very freely removed, but probably not more so than was very commonly done. There was nothing in the man's history or in the behavior of the wound at the time of the operation which suggested that he bled more readily than other people.

In two previous cases he had had no difficulty in controlling the hæmorrhage with his finger and thumb. The reason why he had tied the common cartoid was that, upon his excision exposing the external and common carotids, he found a very large pharyngeal artery present, and that other branches of the external carotid arose close to that vessel. He had often ligatured the common carotid, and had never known subsequent cerebral trouble arise. This immunity he attributed to the fact that he always injected the saline solution, the desirability

of which precedure he strongly advocated.—From the report of the London Clinical Society, *British Medical Journal*, April 30, 1892.

SPONTANEOUS RECOVERY FROM GANGRENE OF INTESTINE.

An interesting case of recovery by sloughing of the gut is related by Dr. Duncan Cooper (*Brit. Med. Jour.*, May 14, 1892). He says: The patient, a married woman, 24 years of age, giving a history of previous constipation, called me in on December 7th, 1891. She had then been seven days without having any movement of the bowels. An enemata of soap and water was ordered, but this had no effect; the usual purgative treatment had the same negative result.

The obstruction continued for five weeks; and, as an operation was not allowed, Dr. Samuel Fenwick was called in. Nothing of importance could be made out, with the exception of large masses of scybala, but no tumor could be discovered. At Dr. Fenwick's suggestion, I inserted a piece of rubber tubing, 2½ feet in length, into the rectum, and passed an enema up by this means, and continued the same treatment for a week. Symptoms of peritonitis supervened; after keeping the patient under the influence of morphine by the hypodermic method they subsided. The constipation still remained, however, and on February 29th, 1892 (eighty-four days after coming under treatment), when the patient appeared to be getting stronger, I administered an enema of five pints of warm water and soap. This she retained for half an hour, when she passed a piece of intestine 3½ inches in length, evidently from the ileum. This was followed by a very copious motion, consisting of scybala and mucus. The enema treatment was continued on March 1st, 2nd, 3rd and 6th.

On March 7th, after similar relief, I put her on cascara sagrada, with liquid food, and she is now convalescent.

During the whole time the patient was under my care I kept her upon whisky and beef tea, with plenty of ice, and on rare occasions a little milk.

The following points are worthy of notice in this case: 1. No tumor could be discovered. 2. Very slight discoloration by jaundice took place. 3. There was no stercoraceous vomiting. 4. Very little blood or mucus was passed by the rectum. 5. The exceedingly small amount of wasting. One would have expected to find a great deal more, considering the diet was so limited. I attribute this to the free use of opium, thereby preventing any great amount of metabolism in the tissues. I believe this to be the longest case on record, with complete obstruction, where recovery took place.

ON THE DANGERS OF WASHING OUT THE STOMACH.

In the current number of the London *Practitioner* there is a valuable and timely article by Dr. Soltan Fenwick, of London, on the dangers of washing out the stomach. After pointing out the usefulness of this therapeutic measure in suitable cases, he deals with the dangers attending it, and the harmfulness arising from its employment in unsuitable cases.

Twenty-five cases of convulsive seizures in chronic diseases of the stomach are collected, and in six of these the attacks were apparently brought on by the use of the stomach tube. Both general convulsive seizures and tetany may be brought about by any irritation other than by mechanical means of the gastro-intestinal canal, but in some of the cases reported by Dr. Fenwick it is impossible to eliminate the stomach tube as being the active factor. Tetany arising from gastric disturbance is very fatal, upwards of 60 per cent. proving fatal. A case of perforation of a gastric ulcer occurring immediately after the use of the stomach tube is reported. Hæmorrhage from the use of the stomach pump is

not uncommon in cases where there is at the time ulceration of the mucous membrane, as in carcinoma and chronic ulcer.—*Montreal Med. Jour.*

OPERATION FOR RECURRING DISLOCATION OF THE LOWER JAW.

In the *British Medical Journal*, April 30, 1892, Dr. Marsh, of Birmingham, writes:

Mrs. A. O., aged 23, a stout, healthy-looking woman, was admitted into Queen's Hospital under my care on May 13th, 1890. Five months previously, and a fortnight after confinement, she bilaterally dislocated her lower jaw when gaping. It was reduced, but in a fortnight's time was again dislocated by gaping. Since then recurrence has been frequent, some days happening many times—in fact, almost always if the mouth is incautiously opened. The dislocation is always easily reduced by her usual medical attendant, but if she is away from home difficulty is sometimes experienced, and the manipulation causes her considerable suffering. Restraining bandages had been worn, but the patient objected to them as a permanence, and was extremely anxious to have something done, and was willing to submit to any operation offering even a chance of relief.

On May 15th, under anæsthesia, the left temporo-maxillary articulation was exposed by an incision about an inch long, extending downwards from the zygoma, half an inch in front of the auricle. The capsule was opened and the interarticular fibrocartilage was found to be exceedingly loosely attached. The external lateral ligament could be clearly defined. Following Professor Annandale's method of fixing the cartilage in cases of subluxation, a catgut suture was passed through the periosteal attachment of the capsule to the zygoma and through the margin of the cartilage; but in tying it in the deep and narrow wound it cut through the cartilage; fine silver wire was substituted, twisted and cut off short. A second suture was now passed through the external lateral ligament and through the periosteal attachment of the capsule as far posteriorly as possible, so as to make a fold or tuck in the ligament and bind it down to the adjoining structures. The wound was then closed. It was anticipated that these sutures, assisted by the adhesions which would form during the healing process between the exposed part of the capsule and the surrounding tissues, would fulfill the first two aims of the method, and that careful asepsis would ensure the third.

Primary union took place, and in twelve days the patient returned home, wearing an elastic bandage to restrain movement, and for a time being limited to slop diet. She wore the bandage continuously for two months, and during this time there was no recurrence on either side. When she ceased to wear it dislocation of the right condyle soon took place, and became of frequent occurrence; the left remained in place in spite of extra strain thrown upon it during the manipulation for reducing the opposite side. The right articulation was therefore operated upon in a somewhat similar manner on September 25th, 1890, but only one silk suture was used; this was passed through the external lateral ligament, the periosteal attachment of this capsule on the outer side of the glenoid margin, the interarticular fibrocartilage, back through the external lateral ligament, and then tied. Primary union again took place, except along a small drainage tube track, and the patient went home on October 8th, observing the same precautions as on the previous occasion.

Since the second operation there has been no recurrence of dislocation, and no trouble whatever has been experienced from the buried sutures. The cicatrices are hardly visible even on close inspection; there is a distance of 1½ in. between the front incisor teeth when the mouth is open, and when the jaws are

closed the teeth meet accurately. She can open her mouth widely or gape without fear, and can eat anything; she is, in fact, *re* the dislocation, perfectly well.

The operation, though apparently simple, is not a very easy one to perform. The wound must be limited in length because of the anatomical surroundings; the tissues cut through are very vascular, and it is difficult both to pass the suture, and to tie it sufficiently tight without cutting through the fibrocartilage. On this latter account aseptic silk or tendon will probably be found the most suitable material for the suture. In view of the possibility of suppurative arthritis and subsequent ankylosis, it is advisable to operate on one side at a time. The second operation should preferably take place soon after the healing of the first wound, and before the elastic bandage is discarded.

A sufficient length of time has now elapsed—over eighteen months since the second operation—to establish beyond doubt the permanent character of the result obtained by this method of treatment, the success of which has in this instance been so complete as to justify its employment in other similar cases.

Medical Items.

Dr. Austin Flint has been decorated by Venezuela and been accorded the order of the Liberator.

The Mississippi Valley Medical Association will hold its eighteenth annual session at Cincinnati, Ohio, Wednesday, Thursday and Friday, October 12, 13 and 14, 1892. A large attendance and a valuable programme are expected. President, Chas. A. L. Reed, Cincinnati; Secretary, E. S. McKee, Cincinnati.

Dr. Shibasaburo Kitasato, who for six years has been doing bacteriological work in Berlin, largely in Koch's laboratory, and whose name has become widely known in connection with his work on immunity, has been recalled by the Japanese Government to take the direction of an Institute for Infectious Diseases in connection with the University of Tokio.

In constipation occurring in the thin and anæmic, the efficiency of sulphate of magnesium can be much increased by the addition of gr. j–ij of sulphate of iron, taken before breakfast each morning. However, if the patient be of full health, robust and plethoric, you can add to the Epsom salts with much advantage gr. 1-16 to 1-12 of tartar emetic.—*Pittsburg Med. Rev.*

The *Boston Medical and Surgical Journal* states that a company, to be known as the Boston Bath-house Company, is soon to be incorporated to establish baths for the poor of Boston, following the steps of the chief European cities and the recently established People's Baths in New York. There is already a small establishment of this kind in Boston, where, during the first year, 3,000 men, women and children made use of it. It is hoped that after the baths are established they will be self-supporting. About $40,000 are needed for the establishment of the institution.—*Med. Rec.*

Prof. Wm. H. Keen, on the 4th inst., performed an amputation at the hip-joint upon a lady who was suffering with a rapidly-growing sarcoma of the thigh, and who had been sent from Brazil to see what could be done for her relief. What makes the case probably unique in surgical annals, is the fact that she was in the fifth month of pregnancy at the time of the operation. The arteries were controlled by Wyeth's method, and scarcely any loss of blood occurred. Last

accounts showed entire absence of fever, and patient doing well. A detailed report of this case will be published soon.—*Amer. Prac. and News*, May 21st.

The Board of Trustees of the Jefferson Medical College, at their meeting, on April 7th, 1892, instituted a Chair of Clinical Gynæcology, with a seat in the Faculty, and elected to the new chair Dr. E. E. Montgomery, who has been for a number of years Professor of Gynæcology in the Medico-Chirurgical College. They also established the following Clinical Professorships, electing Dr. F. X. Dercum, Professor of Nervous Diseases; Dr. E. E. Graham, Professor of Children's Diseases; Dr. H. Augustus Wilson, Professor of Orthopædic Surgery; Dr. H. W. Stellwagon, Professor of Dermatology; and Dr. W. M. L. Coplin, Adjunct Professor of Hygiene.

The *Medical Press* reports the case of a woman who had for a long time suffered from chronic intestinal catarrh. After death the cæcum was found to be occupied by a large greyish mass, which readily broke down under pressure. On examination this was found to consist of 85 per cent. of bismuth subnitrate, together with 15 per cent. of organic matter. The patient had, for a long time before her death, been accustomed to take large quantities of bismuth subnitrate in the usual routine prescriptions for gastro-intestinal catarrh.—*Med. Standard.*

In order to elucidate the character of the secretion of bile in artificially induced uræmia, Dr. Lokianoff, of Warsaw, tied the ureters close to the bladder in twelve guinea-pigs, collecting the bile of six of these during the first day and of the remaining six during the second day of uræmia. He found, among other results, that uræmia tends to reduce the body temperature; as a rule, the liver increases in weight to a slight extent, the blood and the kidneys become richer and the liver and brain poorer in watery constituents, and the secretion of bile is rather less than normal. The production of hepatic tissue is diminished, especially as the uræmia progresses. The bile secreted is poorer in water and richer in solid matters than in the normal condition or in the first stage of starvation.—*Lancet.*

The Registration Committee wishes to give notice to all who expect to attend the ensuing meeting at Detroit, that those who desire to do so can register by mail. The Committee will send to each member of the Association, within a short time, the proper blanks, and earnestly desires that as many members as possible will forward to the Committee their credentials and fees *in advance of the meeting.* By this means we expect to lessen very greatly the annoyance which the members always experience in waiting in a great crowd around the registration clerks. Those who register thus, by mail, will save themselves all delay and annoyance. Think it over, and when you receive your blanks, sit right down, fill them out, enclose your fee and send it right on to the Committee. David Inglis, Chairman, 21 State St., Detroit, Mich.

By a recent law no medical officer in the army can be promoted to the rank of captain until he has passed an examination for promotion. Heretofore the medical officers of the army have been promoted to the rank referred to at the end of five years' service without an examination, while their less favored brethren of the navy and of the marine-hospital service have had to prepare at the end of three and four years, respectively, for an examination preliminary to promotion that was quite as rigorous as that given for admission into the corps. The Senate has recently passed a bill giving to officers of the medical corps holding the rank of colonel the grade of assistant surgeon-generals, and to those holding the rank of lieutenant-colonel the grade of deputy surgeon-generals. These are

new titles in our army and are similar to those of the British army medical corps. —*Boston Med. and Surg. Jour.*

The Statue to Dr. J. Marion Sims, which is a full-length figure in bronze, nine feet in height, has arrived in this city and will soon be ready for the inspection and approval of the Committee on Statues of the Central Park, after which it will be duly presented to the city. The sculptor, Ferdinand V. Miller, of Munich, Bavaria, has not only succeeded in making a life-like picture of the distinguished gynecologist, but has given an artistic grace to the pose which will challenge criticism. The pedestal, which will be of granite and eight feet in height, has been especially designed by the same artist, to be in harmony with the line and purposes of the figure. It is expected that the monument as a whole will be completed and placed in its position within the present year, as a lasting tribute to the subject by the members of the profession in this country and other patrons of the civilized world.—*Medical Record.*

To take care of objectives and eye-pieces: It is as necessary to keep these as *free from dust* as the stand; in fact, even greater cleanliness should be observed. When indistinct, dark specks show in the field, the cause may usually be looked for in the field-lens, although sometimes in the eye-lens also. The dust may be removed by a camel's-hair brush, but when this is not sufficient use a well-washed piece of linen, such as an old handkerchief. From its fine texture, chamois skin is desirable, but as it is fatty it should never be used until after it has been well washed. The same method applies to cleaning objectives. Clean an immersion objective invariably after it has been used, first by removing the fluid by a moist linen, and then by using a dry piece. Keep the objectives especially in a place where they are not subject to extreme and sudden changes of temperature, as the unequal expansion and contraction of glass and metal may cause the cement between the lenses to crack. Also keep them from direct sunlight. Avoid any violent contact of the front lens with the cover-glass. Usually the latter suffers, but it is as liable to occur to the former.—Dr. Bausch, in *Microscope.*

At a recent meeting of the Philadelphia County Medical Society, Dr. S. Solis-Cohen read an article on Patent Medicines and presented the following resolutions, which, on motion of Dr. J. Madison Taylor, were adopted; the delegates to the Medical Society of Pennsylvania being instructed to officially present and support them:

Resolved, That the Medical Society of the State of Pennsylvania hereby expresses its highest disapprobation of the practice of giving certificates or testimonials to secret preparations alleged to be of medicinal virtue, and calls the attention of the affiliated county societies to the fact that such action on the part of members of the said societies is in derogation of the dignity of the profession, and in violation of the letter and the spirit of the Code of Ethics of the American Medical Association and of this Society.

Resolved, That this Society likewise expresses its disapprobation of the practice of inserting advertisements of secret preparations in the columns of medical journals, such action being an insult to the intelligence of the profession, and a degradation of journals indulging therein to the level of the patent medicine almanac. Especially to be condemned is the action of the *Journal of the American Medical Association* in admitting such advertisements.

Resolved, That copies of these resolutions, duly attested by the permanent Secretary, be sent to all county societies in affiliation with this Society, to the American Medical Association, to State medical societies in affiliation therewith, and to the publishers and editors of American medical journals.

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CONTENTS

ORIGINAL ARTICLES.

Vulvo-Vaginitis in Children. By J. Whitridge Williams, M. D., Baltimore. . . . 705

Report of Committee to Devise Means for Lessening the Amount of Blindness from Curable Diseases. 713

EDITORIAL.

The Children's Fresh Air Society. . . 715

Our Streets. 716

The Ready Doctor. 716

MEDICAL PROGRESS.

Ganglion and Inflammation of Tendon Sheaths. A Mass of Lead Impacted in the Tympanic Cavity, and Removed by the Aid of Metallic Mercury.—Paraldehyde in Insanity.—A Point in the Differential Diagnosis of Rubeola and Rubella.—Therapeutic Use of the Salts of Strontium.—What Lymph Glands are Enlarged in Chancres of the Finger.—Narceine in Influenza.—The Electric Douche.—Cupping in Hiccough.—Phlegmasia Dolens Following Influenza. 717

THERAPEUTIC RECOMMENDATIONS. . . . 725

MEDICAL ITEMS. 725

Original Articles.

VULVO-VAGINITIS IN CHILDREN.*

BY J. WHITRIDGE WILLIAMS, M. D.,

Assistant in Gynæcology, Johns Hopkins Hospital.

In view of the not infrequent occurrence of leucorrhœa in little girls, we thought that it might be interesting to bring to your attention a few cases with which we have met in dispensary practice and then to consider the nature of the affection in the light of recent work upon the subject and our own investigations.

In all, we have seen eight cases of leucorrhœa in little girls and will give a brief outline of their histories.

CASE I.—S. W., aged 3 years. Four months ago her mother noticed a profuse discharge which came on suddenly and has continued ever since; the discharge being so profuse that it became necessary to change her clothes several times a day. There was no difficulty in walking, and only for a few days was there pain on micturition. On examination, a thin yellowish discharge was seen bathing the parts and coming from the vagina; the vulva was markedly reddened, but not swollen; the vagina was also reddened. The mother stated that ascarides had been found in the stools of late. Gonococci was found in the secretion. The case was treated at first by the introduction, twice a week, of iodoform suppositories and later by the application of silver nitrate, 30 grains to the ounce. Case discharged cured at the end of three months.

CASE II.—R. W., aged 5 years. Marked yellowish, muco-purulent vaginal dis-

*Read before the Medical Journal Club of Baltimore.

charge for the past week, with considerable pain on passing water. Examination showed the genitals red and swollen, and a vaginal discharge; no pus in urethra.

An older sister, seven years old, had a similar discharge for the past five weeks. A grown brother was said to have gonorrhœa and the children used his towels. Many gonococci (?) were found in the secretion. Case only seen once.

Case III.—L. G., aged 2 years. For the last month has had a whitish discharge from the vagina, not very profuse. Vulva only slightly reddened. Another child, 3 years old, living in the same house, had a similar discharge. Diplococci of all kinds found in the discharge, some within the leucocytes.

Much improved after a month's treatment with silver nitrate applications.

Case IV.—A. B., aged 8 years. One week ago a profuse yellowish discharge came on suddenly, accompanied by frequent and painful micturition. The child had ophthalmia when a few weeks old, and its mother has now a profuse leucorrhœa, which she attributes to gonorrhœal infection from her husband some years previously. An older sister, with whom the child sleeps, had a similar attack several years before. Mother and children all use the same toilet articles. On examination, the genitals were markedly reddened and sensitive and bathed in a considerable amount of yellowish muco-purulent discharge. Gonococci was found abundantly in the discharge. Treated with iodoform suppositories and application of silver nitrate; marked improvement after a month's treatment.

Case V.—E. B., aged 3 years. When first seen there was a slight muco-purulent discharge, which had been first noticed about a month previously, when it was quite profuse. The mother has had a leucorrhœa for the past six or seven years, but gives no history of gonorrhœa. On examination the parts were not inflamed, and only a small amount of whitish discharge could be seen. No gonococci could be found. Discharged cured after six weeks' treatment with silver nitrate applications.

In the other three cases there had been a purulent discharge from the vagina, for periods varying from one day to a year; they all presented histories similar to the above, but as they were not examined microscopically, we will not consider them in detail.

From a consideration of these eight cases it will be seen that five of them were examined as to the presence of micro-organisms; and, of the five, four contained what appeared to be gonococci.

Before considering our results in detail, it will be interesting to consider the current views concerning this affection. Most of us have been taught to consider leucorrhœa in little girls as indicative of a scrofulous or other constitutional taint; or as secondary to some eruptive disease; or due to some irritation of the parts, by masturbation or the emigration of ascarides from the rectum into the vagina; and in some few criminal cases as the result of gonorrhœal infection. While all these factors may, and occasionally do, play a part in the production of the disease, it is usually due to some infectious cause. This fact has long been recognized, and as long ago as 1853 Barthez and Rilliez[2] stated as the result of their observations, that most cases were of infectious origin. Of course it was not until the discovery of the gonococcus that any positive attempt could be made to identify this affection with gonorrhœa, except in criminal cases; but for years this connection was considered so probable that there was but little hesitation in considering such cases as gonorrhœal in origin.

Thus, in 1878, the year before the discovery of the gonococcus, Dr. John Morris,[13] of this city, wrote an article, in which he stated that the affection was very frequent, and was often of gonorrhœal origin; and that it was practically

impossible to distinguish between the gonorrhœal and non-infectious forms of leucorrhœa in children.

The same year, Dr. J. E. Atkinson[1] reported an epidemic of six cases of infectious vaginitis occuring in a charitable institution in this city. He considered the children to have been infected from cases of ophthalmia, then in the institution, and that the disease was spread by the habit, which many of the girls had, of playing with each other's genitals.

In 1883, Pott[15] reported 44 cases of vulvo-vaginitis, which he had seen during the past six years in the children's clinic at Halle. He considered most cases were of gonorrhœal origin, and designated the mother, who had been infected with gonorrhœa, as the source of infection; the opportunity for infection being afforded by the fact that among the poorer classes the mother and children usually sleep together and use the same towels and linen; and also by the fact that if several children sleep together, and one of them becomes infected, the others are certain to be infected also by playing with each other's genitals. In one instance, which he cited, a mother and four children suffered from leucorrhœa at the same time.

Hirschberg,[9] in 1884, published six cases of severe gonorrhœal ophthalmia, which he had seen in the course of six or seven years, as the result of infection from genital secretions of children. In one case, in which the eye was lost, the child had infected the eye by tranferring the genital secretions to it with its fingers.

The first attempt to find a micro-organism which could account for the infectious nature of these cases was made by E. Frankel[8] in 1885, when he published the results of the microscopical examination of 62 cases, which he had seen in scarlet fever wards in Hamburg. In every case he found diplococci, which did not differ in appearance from the gonococcus of Neisser, except that they failed to stain with cold solutions of methylene blue. A small quantity of the secretion, dropped into the eye of a child, which was expected to die in a short time, caused in four days a muco-purulent discharge, in which the same micro-organism was found; no organisms grew on cultures made from the secretion. In none of these cases was there any sign of urethritis, and in view of this fact and the difference in staining, he concluded that he was not dealing with the gonococcus, but with a separate organism, very similar to it, which gave rise to the vaginitis. As there was no opportunity for the children to play with each other's genitals, Frankel supposed that the infection was due to lack of cleanliness on the part of the attendants, and to the general use of the same chambers and bath-tubs. The discharge in most of the children was only cured after five to six weeks or more of treatment.

The publication of Frankel's works led Cseri[5] to publish his own work on the subject. After considering what were considered the usual causes of the affection, all of which he admitted might give rise to the disease, he concluded that a distinctly infectious form of vaginitis existed, which was of far more frequent occurence than the other forms. He examined 26 cases of this variety, and in all of them found an organism, which corresponded microscopically in all respects to the gonococcus of Neisser, and, in spite of the fact that he obtained no positive results from culture and inoculation experiments, did not hesitate to conclude that the affection was identical with the blenorrhagic affections of adults. He was strengthened in this supposition by the fact that in four of his cases conjunctivitis also occurred, evidently as the result of infection. Contrary to the statement of Frankel, he found that the organism stained equally well

with cold solutions of staining material. His ideas concerning the modes of infection are identical with those of Frankel.

Between the years 1884 and 1886, Widmark[25] made three communications on the subject, covering, in all, 22 cases of the disease. In all he found what he considered to be gonococci; and some of his cases are most interesting as illustrating possible modes of infection and the identity of the disease with gonorrhœa. Thus, in three cases he found the organisms not only in the vaginal secretions of the children, but also in those of mothers: and in several of these, the mother stated that she used the same washcloth and towels for herself and child.

In another case the mode of infection was quite clear; a five year old girl had a profuse purulent discharge, and it was found that both of the children, younger than herself, had had ophthalmia neonatorum soon after birth; in this instance abundant opportunity for infection was afforded by the general use of toilet articles. In another case, a nine year old girl had a gonorrhœal vulvo-vaginitis, and in a short time a purulent urethritis appeared in her eight year old brother, gonococci being found in the pus. A case illustrating the converse of this was recently reported by Crandall,[4] in which a six year old boy infected his sister with gonorrhœa, gonococci having been found in the discharges from both of the children.

In 1885, Lennander[12] reported ten cases which were seen in the children's hospital at Stockholm, in five of which gonococci were found. Israel[11] the next year reported 11 cases, in nine of which he found gonococci. Similar cases were also observed by Prettyman,[17] Eroess[7] and Hofmokl.[10]

At the German Gynæcological Congress of 1888, Pott[16] reported the cases that had occurred in the children's clinic at Halle during the past twelve years. Of 8,481 girls that had been treated for all causes, 86, or a little more than 1 per cent., had a vulvo-vaginitis. Most of them he considered of gonorrhœal origin, the vast majority of them occurring in children between the ages of two and four years. In a few instances he stated that the infection was due to criminal action. This he thought was due in great part to the prevailing superstition that connection with a virgin would heal the "clap." In a few instances it was observed in newly born children, when it was evident that they had been infected during birth; in other cases, the child had both ophthalmia and vaginitis, while in still other cases it had only the ophthalmia and the vaginitis was due to secondary infection. He accounted for the occurrence of the vast majority of cases in children between the ages of two and four years, by the usual mode of living among the poorer classes —thus, the first child enjoys the luxury of a separate crib until a second child is born, when it is usually taken to bed with its parents, where it is more exposed to infection: and as the family increases in size, several children occupy the same bed, and if one becomes infected, infection of the others is sure to follow. He also stated that the majority of cases which occurred during eruptive and constitutional diseases were also of gonorrhœal origin and not merely the result of the disease. His idea being that the diseases in question caused a hyperæmic condition of the vaginal and vulval mucous membranes, which thus afforded the most favorable conditions for infection.

In the discussion which followed, Prochownik[18] stated that from his own observation he could heartily indorse what Pott had said; and Saenger[20] stated that he had often observed family epidemics, and that sometimes the results of infection were far more serious than was generally supposed, as the following case proved: A woman eight months pregnant was infected by her husband and as the result had severe cysto-uretero-pyelitis and gonorrhœal cervical catarrh; the child was

born on the 30th week of pregnancy and had an ophthalmia; in a few days its 3½ year old sister developed vulvo-vaginitis, which was followed by a severe attack of undoubted pelvic peritonitis, which terminated in recovery after three weeks. He believes that the rare cases of pyosalpinx in virgins are to be considered due to gonorrhœal vaginitis contracted during childhood.

Suchard,[24] a physician at Lavey, a Swiss watering place, reported two interesting epidemics, which apparently originated from the general use of the same bath tub. In one case, twelve girls from 12 to 14 years old used the same tub and all of them developed a mild vulvo-vaginitis, which was healed in about a month. Two months later a similar epidemic occurred under the same conditions and eleven girls were affected.

Von Dusch[6] at the Heidelberg children's clinic in the course of two years saw 19 cases and in all of them he found the gonococcus. Indeed, he stated that since the discovery of the gonococcus he had never failed to find the organism in all the cases of vulvo-vaginitis which have come under his care. He considered that the marked susceptibility of children to the affection is due to the same conditions which render them more susceptible than adults to all infectious diseases.

In 1889, F. Spaeth[22] reported 21 cases of vulvo-vaginitis, in 14 of which he was able to demonstrate gonococci both in the vaginal and urethral secretions, while in the other seven he found all sorts of micro-organisms. Of these seven, 3 were due to ascarides, 2 to masturbation and 2 to criminal attempts at copulation. He considered that there could be no doubt in these cases as to the identity of the affection with gonorrhœa.

In 1889, Steinschneider,[23] assistant to Neisser, examined the secretions of five girls, all suffering from vulvo-vaginitis, for gonococci by the Gram method and then stained with Bismarck brown, and in all of them found gonococci and had no hesitation in stating that they were all of gonorrhœal origin.

By far the most interesting article in this connection was written last year by R. Skutsch,[21] who recorded an epidemic that occurred in Posen in August, 1890. During August and September of that year, he saw and treated in the polyclinic 160 cases of vulvo-vaginitis. The children all belonged to the poorer classes, and apparently contracted the disease by the use of baths at a free bathing institution in the city. The disease was of a very intense variety, and was accompanied by marked constitutional symptoms; in many cases there was also a marked urethritis. All the cases developed within a period of one to two weeks after taking the baths; the number of baths taken before the appearance of the affection varied considerably—from one to six or more. The nature of the affection was not at first suspected, and it was not for several weeks that the secretions were examined for gonococci, which were found. It appears that abundant opportunity for infection was afforded by the fact that several children always bathed together in the same tub, and that frequently the same water was used more than once. The disease proved extremely intractable to treatment, and in many cases lasted for months. After the cases had been under treatment for about ten weeks it was suggested by Prof. Neisser that the secretions from all the children be examined. Accordingly, Dr. Steinschneider, his assistant, examined the secretions from 140 cases, and in 60 of them (43 per cent.) found typical gonococci by staining by the Gram method, and then with methylene blue; and in 55 cases, in which the urethral pus was examined, gonococci were found in 37 per cent. of the cases. From the fact that in nearly one-half the cases, even after ten weeks' treatment with injections of all sorts, gonococci were still found, Neisser and Steinschneider had no hesitation in considering that all the cases had been of gonorrhœal origin.

When one considers all the work that has been done upon this subject, one would think that there could no longer be any doubt as to the gonorrhœal nature of the affection; but when one considers all that is necessary to prove such a position, one readily sees that it is yet far from being absolutely established. In the first place, admitting that gonococci are the cause of gonorrhœa, it is extremely difficult to be sure that one is dealing with the gonococcus, and not with some other organism. The mere presence of diplococci in vaginal secretions proves nothing at all, for Bumm[3] has shown that seven different forms of diplococci may be found in the vagina. It was then stated that the presence of diplococci within the leucocytes, arranged in little groups of two or four, was absolutely distinctive of the gonococcus, but unfortunately it has been shown that staphylococci may also invade the leucocytes and give rise to the same appearance.

In 1886, Ronx[19] pointed out this fact, and stated that gonococci were not stained by Gram's method, while all the other diplococci were, and that to be certain that one has to deal with them, one must first stain the specimen by Gram's method, and then with some other stain, as methylene blue or Bismarck brown, when the gonococci will be stained light blue or brown, and all the other organisms a deep violet. A careful review of the literature, however, shows that the only cases which have been submitted to this criterion have been those of Steinschneider and Skutsch.

Unfortunately the diagnostic value of the gonococcus has been still further assailed, and the last authoritative statement on the subject was made by Neisser[14] two years ago, when he stated that in order to prove that one has to deal with the gonococcus, one must fulfil the three following postulates:

1. Typical arrangement of the diplococci in the leucocytes.
2. Inability to stain the organisms by the Gram method.
3. Inability to cultivate the organisms on the usual culture media—agar-agar and gelatine.

As far as I can learn, none of the investigators in this particular line of work have fulfilled all these demands, and so they cannot be said to have proven absolutely that vulvo-vaginitis in children is of gonorrhœal origin.

When we recall the cases whose histories are at the beginning of this article we will remember that we found apparent gonococci in four out of the five cases which were examined for micro-organisms; but we regret to say that only in two of them was the Gram method of staining employed.

This accordingly places us in the same category as Steinschneider[23] and Skutsch,[21] and we are compelled to admit that none of us have yet absolutely proven that we have to deal with gonorrhœal infection in these cases.

Of course absolute certainty can only be attained by cultivating the organisms in pure culture and producing gonorrhœa by their inoculation.

Unsatisfactory as the results of bacteriological investigation in this affection have been, when we consider the clinical histories of the cases, we can not but admit that the probability of the gonorrhœal origin of most cases is so strong as to amount almost to certainty.

As stated at an earlier point in this article, gonorrhœa can not be said to be the cause of all cases of vulvo-vaginitis in children, but from the consideration of our cases and those reported in the literature, we will readily see that the other causes sink into insignificance when compared to this; and as a prophylactic precaution, we are justified in treating all cases as infectious, except those for which we can find some other perfectly definite and satisfactory cause, as ascarides or masturbation.

From what has been said, the affection is seen to run a very chronic course and to prove very intractable to treatment.

The clinical history of the affection varies greatly, according to the intensity of the inflammation and whether or not it involves the urethra. In mild cases the genitals are hardly reddened at all, and all that attracts attention is a thin watery discharge from them.

In more severe cases, however, the vulva is swollen, markedly reddened, with occasional bleeding points, very sensitive to the touch, and bathed by a profuse muco-purulent discharge. The inflammation may be seen to extend to the vagina, from which a great part of the secretion may be seen to flow. Ordinarily there is not much pain or constitutional disturbance, but occasionally there is a slight rise of temperature, with anorexia and depression. On the other hand, if the urethra be involved in the inflammatory process, there is always more pain, with frequent and painful micturition; sometimes the pain is so great that the child cries at every attempt to urinate.

The acute stage of the affection soon passes off, but a chronic discharge may remain and continue for an indefinite period. Indeed, even with good treatment, it is not at all uncommon to find the discharge continuing for three months or more.

In the non-infectious form, the symptoms are less pronounced, and the discharge usually disappears almost as soon as the cause is removed.

Diagnosis.—From what has been said it is seen that it is impossible to distinguish between the infectious and non-infectious forms except by means of the microscope. So, for general practice, the best rule is to consider all cases as infectious unless we are certain that they are due to irritation of some sort.

The probable gonorrhoeal origin of most cases of the disease has a very important medico-legal bearing. Owing to the frequency of perfectly innocent modes of infection, the supposition that a gonorrhoeal vaginitis is due to criminal action could only be justified in a very small proportion of cases, in which the circumstantial evidence was of the most complete nature; and in view of the uncertainty about distinguishing the gonococcus, such a case would be most difficult to prove.

Treatment.—Non-infectious cases are to be treated by removing the cause. All infectious cases are to be treated with the most scrupulous cleanliness and with every precaution to prevent further infection. The child should be supplied with its own toilet articles and be taught the danger of handling its genitals; and its attendant should be most careful in cleansing herself after caring for the child. In the vast majority of cases, constitutional treatment alone will not cure the disease, and sooner or later we are obliged to resort to the use of local applications. Those that we have found most efficacious have been the introduction of suppositories of iodoform and cocoa butter into the vagina, and the application of silver nitrate. Of the two, the silver nitrate applications are far superior; a solution of thirty grains to the ounce should be applied to the vagina twice a week by means of a small sound covered with absorbent cotton, until the discharge ceases. Frequently the parts are so sensitive that the child can not bear the application, and in these cases it is well to apply a little cocaine before making the silver application. If this fail after a good trial, we should then resort to the use of suppositories of iodoform. Whatever the mode of treatment, the genitals should be frequently cleansed with warm water and Castile soap and then dusted with boracic acid.

CONCLUSIONS:

1. Vulvo-vaginitis is quite frequent in children, occurring in about 1 per cent. of all dispensary cases.

2. Most cases are infectious and in all probability of gonorrhœal origin.

3. Its gonorrhœal nature has not yet been absolutely proven by bacteriological research.

4 The most frequent mode of infection is indirectly from the mother or some other member of the family, by means of the general use of the same toilet articles, or by the children playing with each other's genitals. Occasionally the infection occurs from a case of ophthalmia, and in rare cases from infection at birth or from criminal action.

5. The affection runs a very prolonged course and usually does not cause much constitutional disturbance.

6. In rare cases it may lead to serious internal trouble, as salpingitis and pelvic peritonitis.

7. The diagnosis between the infectious and non-infectious varieties is only possible by means of the microscope; as a matter of precaution all cases are to be treated as infectious.

8. The most efficient treatment consists in extreme cleanliness on the part of the child and its attendants, and local applications of a solution of silver nitrate.

9. In children's hospitals such cases should be isolated.

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In acute, and especially in chronic gastritis, Menche recommends resorcin in solutions with muriatic acid, tincture of rhubarb, sodium bicarbonate, or in powders, from a grain and a half to eight grains at a dose. Acid eructations, vomiting, sense of a load in the stomach, were all relieved and appetite improved. Favorable effects were observed in dilatation of the stomach and in carcinoma. Contra-indicated in fresh ulcus ventriculi.—Dr. Sanger, in *Cleveland Med. Gaz.*

REPORT OF COMMITTEE TO DEVISE MEANS FOR LESSENING THE AMOUNT OF BLINDNESS FROM CURABLE DISEASES.†

Mr. President and Gentlemen: The committee appointed at the last annual meeting to devise ways and means for the prevention of blindness in the city and State begs to report as follows: The work of the committee has been confined to one disease: Ophthalmia Neonatorum.

After considering various plans which have been tried in other places, the committee concluded that the work assigned it must be accomplished by an educational process. Ignorance, and not indifference or carelessness, is the cause of so much preventable misfortune. It is hard to conceive of a parent, midwife, or physician being careless or indifferent, if they really know the nature of the disease. There is no doubt that most of this ignorance prevails, just where one expects to find it, among parents and midwives; but no thoughtful man will deny that it is not confined to these persons. Of six blind babies, recently observed by the chairman of your committee, three had been attended by midwives, two by physicians, while to the last a physician had been called in when too late. In all the cases save the last, the treatment reported was entirely inadequate.

A circular letter to the midwives of Baltimore was prepared by the committee, and mailed through the City Health Department to each midwife in the city. A copy of this letter, with an accompanying explanatory note, was mailed by the committee to each physician in the city and to many in the State. This letter to the midwives reads as follows:

"Baltimore, October 16, 1891.

"*To the Midwives of Baltimore:*

"The undersigned practising physicians of Baltimore were appointed by the Medical and Chirurgical Faculty of Maryland to take measures tending to diminish the blindness in our city and State. About *one-third of the blind* in our Blind Asylums have lost their sight through a disease which is common among the newly-born. This *fearful disease* which causes so much suffering and unhappiness *can be prevented by proper care. It can nearly always be cured and sight saved if treatment is begun early and kept up.* The disease shows itself by redness and such swelling of the eyelids that the baby cannot open its eyes; the eyes discharge yellow matter. The disease usually begins during the first few days of life. This disease will often cause incurable blindness in forty-eight hours, unless properly treated.

"We ask you to impress upon the mothers you attend the *great danger of delaying treatment.* Do not let them waste valuable time in using breast-milk, chamomile tea, quince water and other home remedies, for *a day lost may rob the infant of its sight.* Insist upon sending the child, as soon as the disease begins, to a physician, or, if the parents are unable to procure one, to a dispensary.

"You can do much toward preventing the disease by thoroughly cleansing the child's eyes immediately after it is born. Wash the eyes carefully with fresh, warm water and a piece of perfectly clean soft linen. Do not use water or linen which has beeen used on other parts of the body, but wash the eyes first of all. You will assist greatly in the important work of diminishing blindness:

"1, By washing the eyes of the newly-born as described above, in order to prevent the disease from attacking them.

†Report of the Committee appointed by the Medical and Chirurgical Faculty of Maryland in April 1891, to devise means for lessening the amount of blindness from curable diseases. Presented at the annual meeting of the Medical and Chirurgical Faculty, April, 1892.

"2. By instructing the mothers whom you attend concerning the *importance of watching the eyes closely during the first and second week.*

"3. By calling attention to the *dangers of the disease,* and the *great urgency of prompt medical treatment.*

Hiram Woods, M. D., Chairman; George H. Rohe, M. D.,
J. Edwin Michael, M. D., Harry Friedenwald, M. D.,
Committee."

Placards designed to call the attention of parents to the necessity of watching the eyes of new-born babies now hang in the waiting-rooms of most of our dispensaries. In the distribution of these placards a few dispensaries were unintentionally overlooked, but they will be supplied. These placards read as follows: "Watch a baby's eyes carefully for a week after birth. If they look red or run matter, take it at once to a doctor. The child may become blind, if not treated properly."

Your committee believes more than ever that such work as was assigned it a year ago is of great importance; that it belongs, indeed, to the most important work the Faculty has to do—educating the public in matters pertaining to health. We are just on the threshold of this work, and your committee respectfully asks to be continued with the same powers given it last year.

If any physician in the State can make use of these letters and placards in the city or town where he lives, the committee will gladly supply him. Such co-operation as this is earnestly asked.

Finally, the committe wishes to thank Dr. James F. McShane, Health Commissioner of Baltimore, for his kindness in mailing the circular letters to the midwives.

Respectfully submitted,
Hiram Woods, M. D., Chairman; J. Edwin Michael, M. D.,
Geo. H. Rohe, M. D., Harry Friedenwald, M. D.,
Committee.

Dr. L. Rochester has used with success the following in cases when the mother's milk was insufficient in quantity, or when it was desired to wean the infant:

℞.—Yolk of egg	. . . .	no. 1.
Sugar of milk	. . .	teaspoonfuls 6.
Filtered water	. . . .	oz. 7.

Dissolve the sugar of milk in the water and add gradually to the yolk of the egg, stirring constantly.

This is fed perfectly cold, in small quantities at a time, for twelve hours, gradually increasing the amount and lengthening the intervals, until finally the full amount is given four times in the twenty-four hours.—*Med. and Surg. Reporter.*

Leopold expresses his conviction that in hysteria there is always a pathological anatomical cause to be sought and found; but by no means always in the sexual organs. As such causes he has repeatedly found floating kidney (treated by a suitable bandage and not by stitching, in which he agrees with Von Bergman and Schramm), and atonic condition of the bowels. In these latter cases relief may be gained by frequent (six or eight) small meals daily, restricted fluid, rest after eating, external massage after meals, and internal, by grains of sand [like our use of bran for the same purpose.]—Dr. Sawyer, *Cleveland Med. Gaz.*

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BALTIMORE, APRIL 11, 1892.

Editorial.

THE CHILDREN'S FRESH AIR SOCIETY.

While Socialism in its various sects is seeking to prove to the world that society must be forced into new grooves by legislation before the weak and feeble among mankind can get their proper portion of the comforts and enjoyments of life, Christianity is quietly searching for remedies, already at hand, which may be applied in the existing state of society. In every community we find individuals or groups of philanthropists who have learnt the lesson, so beautifully expressed in verse by Lowell in his "Vision of Sir Launfal," that the lost privileges of human brotherhood will never be restored by proud enterprises of the great and powerful; nor by the haughty "benevolence," which casts a piece of gold to the despised and feeble by the wayside; but by the spread of that true sympathy which leads a man, in whatever station he may be placed, to *share* with those less fortunate than himself whatever of good he possesses, even though it be but a crust of bread.

In this spirit certain of our citizens have of late endeavored in various ways to secure summer vacations for those who have not the means to leave the city. We understand that one excellent enterprise of this sort for giving holidays to working girls, the "Vacation Lodge," is wholly self-supporting. Among the enterprises which are not self-supporting the Children's Fresh Air Society deserves especial mention, as giving the greatest amount of benefit with the least expenditure of money.

This society sends boys and girls, who could not otherwise get out of town, to farmers and others throughout the State, who will take them for periods of two weeks during July and August free of charge. In this way fifty-three children got delightful vacations last summer, as recorded in our JOURNAL. Their country hosts expressed themselves in every way pleased with the conduct of their little guests, whose presence brightened their homes. Each child was examined by a physician before leaving the city to see that it had no contagious disease.

We hope that our country readers will bear the society in mind and speak of it to their neighbors this summer, for there must be many families throughout Maryland where a couple of boys or girls who are able to take care of themselves could be taken for a week or two without inconvenience. If our country friends could but visit the streets and alleys of our city on a hot July or August night they would understand what a two weeks' vacation would mean to the city boy or girl.

The number of children sent on vacations will, of course, be limited only by the number of homes offered. Mr. W. L. Smith, 216 N. Charles St., is secretary and general manager. Any offers of homes addressed to the editor of this JOURNAL will be promptly forwarded to the society. Of course, the earlier such offers are made, the better it will be for the purposes of the society.

OUR STREETS.

We are interested to learn that the market men of Richmond market have sent in a petition to the authorities, requesting that Howard Street be sprinkled. We are informed that the store-keepers lower down on the same great and dirty thoroughfare have previously made fruitless protests against the same nuisance. We are personally beginning to doubt whether dust and dirt are injurious to health. In a short ride down Howard Street we have inhaled incredible quantities of street dust without injury. Our friend, Dr. Canfield, must be wrong about dirty occupations causing phthisis, for we have traveled a good deal on Howard Street, and have not even a cough.

It seems that the more one lives in dust and filth the less he is affected. Thus, one of our medical friends and his family were made seriously ill by a sewer excavation which a gang of city workmen thoughtfully left open, with its heaps of foul soil, alongside of his residence on Read Street, all winter; yet we doubt if one of the workmen was prevented by ill health from coming up to the primaries and voting like a little man for the bosses who gave him such a nice long job.

Query: Would not the blood of a sewer-digger be a good thing to inject into the veins of a patient suffering from septicæmia?

THE READY DOCTOR.

An accident on a school excursion a week ago at one of our bay resorts suggests that the doctor should accustom himself to carry certain drugs and instruments in his pockets on all such occasions. It seems that a party of young people were enjoying a "toboggan" ride, when the car ran off the track and threw them all out; injuring all, and breaking the legs of one person.

In such accident cases a doctor is eagerly welcomed, but a doctor would feel very uncomfortable without a little morphia and other simple remedies. It seems a part of our duty to our fellow-men to be always prepared, in season and out of season, to meet with simple remedies any emergency that may arise, especially

when no other professional help is to be obtained. A few tablets in the vest pocket, and a knife and scissors and artery forceps may be of inestimable service, or even save life, in such cases.

Medical Progress.

GANGLION AND INFLAMMATION OF TENDON SHEATHS.

In the *American Journal of Med. Sciences*, June, 1892, Dr. C. S. Evans, of Cincinnati, presents a careful review of this subject. In estimating the comparative value of all the forms of treatment hitherto suggested, he says:

Subcutaneous puncture or discission has, ever since the introduction of this procedure, been a favorite method of dealing with these cysts. It must, however, along with the forcible rupture, be considered as, and only as, a palliative means. The ganglia so treated are sure to return; but as a palliative method it is certainly worthy of consideration: it is much less brusque than the rupturing by a blow, is just as sure, and its dangers are exceedingly small, especially if, as should be insisted upon to-day, thorough antiseptic precautions are taken. So performed, and with the use of a sterilized solution of cocaine, the operation would be almost without danger and painless. Thus, as a palliative method, it should be ranked alongside of rupturing. The presence of danger, of another character from that of suppuration, in those of ganglia which lie on the palmar surface of the wrist, must not be overlooked. These ganglia are most frequently associated with the radial artery either lying beneath or alongside of the same; subcutaneous puncture of this variety might very easily lead to a wound of the artery and the formation of a traumatic aneurism. One must feel some doubt, bearing in mind the anatomy, as to the statement of John Wood, of King's College, London, "that the needle is to be used pretty freely in dividing the cyst wall at its opening of communication with the sheath of the tendon."

Electrolysis of these tumors seems to have been but little used, and yet they are very conveniently situated and well adapted to this method of treament. That it has been practised, and that, too, as long ago as 1871, when electrolysis was comparatively little used, the two cases reported by Wahltuck go to show. Whether a cure accomplished by this method so completely disorganizes the cyst wall as to prevent a recurrence, must remain an open question until more data can be obtained from which to draw conclusions.

Extirpation as a method for the cure of these tumors has of late years grown much in favor; not simply because we know that the great majority of the cysts have no direct communication with the joint or tendon-sheath cavities, but because by virtue of the precaution given by the so-called antiseptic or aseptic method of operating, it is a matter of no consequence, as to the result, whether such a communication existed or not.

Right here a word might not be amiss as to the stringency of the precautions in the smallest detail which must be insisted upon in this operation. One may perform many operations in surgery with no, or with what is perhaps worse, a half-way antisepsis, and achieve results which are not bad; indeed, they may be positively good, but when the tendon-sheaths or joints are liable to be opened, a slip in the method through carelessness, or, what is so prevalent in this country, ignorance or half-belief, is very apt to cause stiff fingers and joints, if not the loss of the extremity. Those who do not trust the method had better not seek its protection.

Without very much doubt, extirpation offers absolute immunity from recurrence, though Koenig (*loc. cit.*) says that even then recurrence may take place. But here it would be very difficult to discriminate between a recurrence and the formation of another cyst.

Clinically, extirpation can only be advised, conscientiously, for those cases which stubbornly recur after treatment by other methods, or those which have some especial symptoms, pain, tenderness, etc., which seriously interfere with the following of the vocation of the person so affected. It is also to be recommended for those cases which lie in close connection with the radial artery.

A MASS OF LEAD IMPACTED IN THE TYMPANIC CAVITY, AND REMOVED BY THE AID OF METALLIC MERCURY.

On April 11th, 1892, I examined a tall, strongly built man, seventy years of age, who was a plumber by occupation, a native of Glasgow, and of the phlegmatic temperament and hardihood characteristic of his race. Six week before I saw him he was carrying a pot of molten lead down the ladder in a ship. The vessel gave a lurch, and he fell, the molten metal splashing over the side of his head and severely burning it. Some of the material ran down the right ear. The agony this caused was indescribable. He lay for five weeks in the Poplar Hospital. The burns improved, and the violent pain and inflammation of the ear were treated by warm and sedative applications. When the swelling had subsided, Mr. Williams, the house surgeon, detected some lead deeply embedded in the ear. Mr. Corner, under whose care the patient had been admitted, kindly transferred him to me for treatment, and I must here acknowledge my indebtedness to his courtesy for the opportunity of seeing and treating this very interesting case.

On examination, I found newly healed burns over the right side of the head. The patient was haggard and worn, and complained of constant pain and discomfort over the right side of the head, originating in the ear. An abundant offensive discharge flowed from the ear, there were ozæna and total deafness on the right side. The tuning-fork was heard long and loud in the mastoid, and the facial nerve was not implicated. On cleansing the ear and examining, a mass of metallic lead came into view. It had burnt through and destroyed the drum, and filled the tympanic cavity, the surface of the lead being just flush with the remains of the membrane. The metal had also entered the Eustachian tube, for on inflating only a feeble current of air could be made to enter the tympanum A preliminary examination with probe and elevator showed the mass to be quite firmly impacted—indeed, the metal had obviously accurately moulded itself to the inequalities of the tympanic cavity, which it completely filled. On April 12th, under good illumination, I made a prolonged and cautious attempt to extract the lead, or at least to shift its position. I introduced a sharp and small, but powerful hook between the floor of the tympanum and the lead. This being turned around took a good hold of the soft metal, and I thus exercised an amount of traction which only the gravity of the case could justify. I was able to take firm hold in like manner of other irregular parts of the mass, but all attempts utterly failed to shift it in the least, and only impressed my mind still more with the firmness of its impaction. I next thought of using a drill and burrs, but was deterred by the risk of the instrument slipping at this great depth, and the presentiment that the soft metal would "choke" the instruments. It seemed that the only feasible method of removal would be by detaching the auricle posteriorly and chiselling away the posterior wall of the bony canal; an operation I was ready to undertake if the symptoms should have continued severe.

I next began to reflect on the possibility of reducing the bulk of the lead by solvents. In conversation with my colleague, Dr. Mott, we discussed this question, and, influenced by his suggestions as to the possibility of mercury forming an amalgam with the lead in the aural cavity, I made some simple experiments. On the night of April 12 I placed pieces of sheet lead in mercury, in solutions of iodide of potassium, in acetic acid, in chromic acid, and in carbonic acid. After twelve hours I examined the lead, and found the specimen that had been in contact with the metallic mercury brittle, soft, and much reduced in bulk, while the supernatant mercury was dark and lead stained. The next day the ear was well cleansed and the patient caused to lie upon his left side. The right ear was filled with liquid mercury, which he was asked to retain as long as possible. On the 15th I noted with satisfaction that when the mercury ran out of the ear it was mingled with lead, being dark-colored, and a plumbic stain was visible on the walls of the canal. A symptom of significance was furnished by the patient also, who felt the mercury run down his Eustachian tube into the throat for the first time. He spat it up at intervals. He also declared that he could feel the lead move. The quicksilver was soaked into the ear for about sixteen hours in the aggregate. The following day I applied a syringe with a long nozzle to the upper wall of the canal, and introduced a powerful jet. Scales of lead escaped, and then followed the mass, which fell with a "chink" into the receptacle. It was of irregular shape, resembling the contour of the tympanum, and coated with mercury. It was reduced in bulk, and all protuberances and angular projections before visible had disappeared.

The mercury had obviously acted as a superficial solvent, had reduced the bulk of the lead, and so allowed the stream of water from a powerful syringe to eject it. The inner wall of the tympanum could now be seen white and bare, apparently necrosed, while abundant granulations were springing from the posterior wall of the cavity. The treatment of perforative otorrhœa must be long carried out. The ossicles seem quite destroyed. The Eustachian tube is quite patent, and a powerful jet of air can now be passed through it.

Pouring of molten lead into the ear was a species of torture well known in the dark ages. I am not aware whether the victims afterwards became surgical patients. So far as I know, this case is unique. The treatment by liquid mercury is also, I believe, novel; and the possibility of employing this agent in cases of impacted bullets at once suggests itself. The case is an important addition to the subject of foreign bodies in the ear, and well illustrates the manifold difficulties which some of such cases present in their treatment.—Dr. A. Marmaduke Sheild, in *Lancet*, April 30.

PARALDEHYDE IN INSANITY.

In a review of the therapeutics af insanity, the editor of the *Medical and Surgical Reporter* writes, June 4, 1892:

Paraldehyde is exceedingly valuable in the insomnia of mental diseases, because besides its hypnotic action it is a circulatory stimulant and can freely be given in cases of cardiac weakness. Its disagreeable taste, the odor it leaves upon the breath for 10 to 18 hours after its administration, and its tendency to disorder digestion are its chief disadvantages. It is nevertheless, in our opinion, one the most serviceable of all the hypnotics used in insane hospitals. It can be employed continuously for a long time without serious effect, although some rare cases of paraldehyde habit have occurred. Out of the many hundreds of cases in which we have seen this drug employed, only one case of paraldehyde habit has occurred, and that was due to an improper use of the remedy

before the patient came under observation. It is more widely applicable to the insomnia of insanity than almost any other drug, and may be safely given in doses of 2 fluid drachmæ, and even as high as half an ounce in severe cases of sthenic mania. It is, however, chiefly of service in the milder forms of mania, and in melancholic states except when employed in conjunction with remedies to control higher degrees of motor excitability. Owing to its excessive pungency it should be given well diluted, so that the stomach may be as little irritated as possible. In epileptic mania it has been found very valuable, and has even been employed as a remedy for epilepsy and the status epilepticus by H. B. Williams, assistant physician of the Arkansas Insane Hospital.

A POINT IN THE DIFFERENTIAL DIAGNOSIS OF RUBEOLA AND RUBELLA.

Dr. Crozer Griffith writes in the *University Medical Magazine*, June, 1892:

There is one symptom of which I have as yet made no mention, but which has long been regarded by many as almost pathognomonic of rubella, viz., the enlargement of the superficial cervical and posterior auricular glands. Could we depend upon this as a characteristic symptom of rubella we should be in possession of a diagnostic feature of great value. A number of writers maintain that this enlargement is one of the prodromal symptoms. I have never had the opportunity of examining for it before the rash had appeared, but I have rarely failed to discover it during the eruptive stage. In fact, there is no doubt whatever that the enlargement during this stage is very widely regarded as—as it in reality is—one of the most constant symptoms of the disease. Yet the truth, though long known, seems largely to have been forgotten, that a similar enlargement may occur in measles. It is certainly safe to say that most practitioners do not look upon enlargement of the superficial cervical and posterior auricular glands as at all a prominent symptom of measles, and probably that few ever examine for it except in doubtful cases.

For some years I have been greatly interested in studying measles with especial reference to this question. Of many of the cases which I have seen I have unfortunately preserved no records, and many even of the records taken were hastily made and necessarily brief and imperfect. There are, nevertheless, 37 cases of rubeola, in which there is recorded an enlargement of the superficial cervical glands, and 11 in which the posterior auricular glands were involved. Of these latter cases 8 belong to the first category as well. In the remaining 3 no note was made of the condition of the superficial cervical group. There are a large number of other records in which the condition of the glands is not mentioned, and which are consequently useless for the present purpose. I find, however, that only in two instances do my notes positively state that no enlargement was present in the glands in question.

It is true that the swelling in the cases of rubeola was usually not as marked as in rubella; it was, however, quite decided enough to nullify very greatly, for me, at least, the diagnostic value of this symptom.

It has been an interesting observation also, to which I can only allude here, to discover enlargement of the superficial cervical glands in several cases of scarlatina, in at least three of which the diagnosis from rubella was made with some difficulty, although the subsequent peeling settled the question beyond cavil.

Inasmuch as it is conceivable that very many children might possibly exhibit a chronic enlargement of the superficial cervical and posterior auricular glands, and that the presence of this symptom in measles might be an accident only, I

have examined a large number of children who were either apparently healthy or were suffering from no eruptive fever, but have found the enlargement in only very few instances, unless the children were very markedly strumous. The conclusion, therefore, seems justifiable, that although this special glandular enlargement is a very constant symptom in rubella, it is probably nearly equally as frequent in rubeola, and that it presents by no means as great diagnostic importance as is usually supposed.

THERAPEUTIC USE OF THE SALTS OF STRONTIUM.

As the salts of strontium have been found to be diuretic when given to dogs, it was expected that they would behave in the same manner in man. On testing them, however, Professor Sée found that diuresis could not be produced by their means even in cases in which it was easily set up in other ways. It was noticed, however, that in patients with Bright's disease, or heart affections, the digestive troubles underwent a marked improvement. This led the author to try the effect of bromide of strontium in gastric affections.

Thirty-two patients, mostly suffering from acid dyspepsia, either with or without dilatation of the stomach, were thus treated, the minimum daily dose being thirty grains, and the maximum a drachm, taken between meals. All showed marked improvement; the diminution of gas formation was very noteworthy. In eight other cases of dyspepsia from reduced hydrochloric acid formation, the drug produced equally satisfactory results, completely controlling fermentative changes and the formation of lactic and acetic acids.

Dujardin-Beaumetz makes the following statements as to the clinical uses of the salts of strontium. The only salt of which he had had any experience was the lactate. This he had employed in a number of cases of Bright's disease, with albuminuria; under its influence he had the satisfaction of seeing the albumen diminish very considerably, in some cases being reduced to one-half of that previously excreted. He attributed this favorable action rather to the very beneficial action of the strontium salts on digestion than to their direct action on the kidneys. At the same time he pointed out that the greater or less quantity of albumen passed was of less importance in the prognosis of the disease than the proportion of toxines retained in the organism, which the renal filter either retains or allows to pass into the urine. He recommended that a milk and vegetable diet be employed in combination with the drug, which he gave in doses of one and a half drachms per diem.

The Uses of Strontium Bromide.—In experimental doses of salts of strontium bromide, in thirty-two cases of dyspepsia, he gave from thirty to forty-five grains a day, in three doses, with meals; and those cases in which there was excess of hydrochloric acid rapidly improved and developed much less gaseous products. In six other cases, where there was vomiting with deficiency of acid, there was complete cessation of the sickness. Strontium lactate did not produce any good effect; strontium bromide, as well as calcium bromide, was found of use by M. Sée in epilepsy; and this was confirmed by M. Feré, who found, in fact, that owing to its easy agreement with the stomach, it was sometimes advisable to give strontium bromide in preference to the potassium salt.—Dr. Williams, *Boston Med. and Surg. Jour.*

WHAT LYMPH GLANDS ARE ENLARGED IN CHANCRES OF THE FINGER.

Dr. Goldenberg closes a letter on this subject to the *Journal of Cutaneous and Genito-Urinary Diseases*, June, 1892, with these remarks: In addition to these cases (in which the *axillary* and not the *epitrochlear* glands have been

found swollen from finger chancre), I have no doubt that a careful perusal of the literature would reveal a great many more. As to the explanation of this fact, let me state that, as far as I know, Lewin is the only one who has given an anatomical reason. Whether or not the latter is based upon personal anatomical researches is unknown to me.

It is a peculiar fact that the opinions of different authors on anatomy, as Sappey, Quain, Henle, Hyrtl and others, differ materially. After a careful examination of the subject, I must say that Lewin's statement does not seem to be correct.

Sappey, who has written a most elaborate work on Lymphatics (*"Des vaisseaux lymphatiques"*) and who is to be considered the best authority on this question, says that the deeper (subaponeurotic) and the superficial (subcutaneous) lymph vessels communicate with each other.

He furthermore states that the lymph vessels which come from the fingers form three principal groups.

1. The median group, which consists only of a few branches and joins the two following.

2. The internal or ulnar group, corresponding to the lymphatics of the fourth and fifth fingers. This group enters as a rule the epitrochlear ganglion. This may be double or triple, or may be absent.

3. The external or radial group, which *always* terminates in the axillary glands.

An affection of the thumb, index and middle fingers, *e. g.*, a chancre, should therefore, as a rule, involve the axillary glands while the epitrochlear should be affected in initial lesions of the fourth and fifth fingers. Sappey states that this is not a mere theoretical conclusion, but is based upon actual clinical observation. There are, of course, exceptions to this rule. In lesions on the radial side of the hands or forearm there may be an epitrochlear swelling, as through the extension of the inflammatory process new anastomoses between the different branches will be formed.

Possibly on closer observation it will be found that in chancres of the first three fingers primary axillary swelling is the rule and not the exception.

NARCEINE IN INFLUENZA.

In the discussion of this disease by the American Climatological Association, September, 1891, Dr. W. C. Van Bibber remarked: As regards treatment, I have used narceine, and have found it exceedingly useful given in small quantities. It controls the disease better than any medicine that I know. I give it in doses of one-third of a grain at night, with one grain each of saccharum album and saccharum lactis, which neutralize the bitter taste of the narceine, and make it rather agreeable. I give it for three successive nights, advising it to be taken after getting warm in the bed, and to use some additional covering so as to increase the cutaneous transpiration.

THE ELECTRIC DOUCHE.

At page 281 of his book on Electro-therapeutics Erb mentions the electric douche. No information, however, is given beyond a reference to a paper by Trautwein. I have not been able to get access to this article, nor am I aware whether the subject has any other literature. It is therefore because it may possibly interest those who are in the same position that I venture to put together the few following points, which are the outcome of an experimental inquiry recently undertaken for my own information. The action of electrized water by means of the electric bath has long been recognized as by far the least painful way of applying the current to the body. But the efficacy of this pro-

cedure depends in most cases on a general and distributed action rather than on any strictly localized effects. The electric douche therefore seems to have been devised as a means of retaining the advantages of the electro-hydriatic method and at the same time presenting facilities for strict localization and accurate dosage, and securing the advantages of labile as well as a stabile action. The method of application, apart from certain non-essential details, is much of the nature of what would be known in hydrotherapeutics as the "movable jet douche" (douche mobile), and the nozzle is so arranged that the electrized steam escapes in the form of a more or less condensed jet or jets, which, with a certain minimum of pressure, remain unbroken and continuous for a reasonable distance after emerging from the pipe, and therefore for that distance retain their electric conductivity. (Of course there ought to be a means of regulating temperature and pressure.) With this arrangement one pole may be placed in contact with some indifferent part of the patient's body, while the other is connected to the internal metal of the douche, with the result that when the douche is set in action the second pole is brought to the patient by and in the fluid, and may be concentrated as a single jet or distributed as many small jets. The fluid is, in fact, the second electrode.

Permanent water pressure not being available, a hand pump drawing from a suitable vessel was used for the douche, which was fitted with a nozzle or rose (having its outer edge insulated with india-rubber) of the size mentioned below. The electric apparatus consisted of a Leclanche battery of seventy-four cells (with a milliampére meter in circuit) and a fair-sized induction coil. One pole was attached to a large electrode on which the patient sat, and the other connected with the metal of the nozzle or rose; well insulated wire being used for the connections. Several readings were taken with alternating current and salt water, all showing that the effect was much stronger with salt water than with plain. These experiments seem to show that electricity can be imparted to the human body by means of the electric douche, provided that sufficient electro-motive force be used and the stream of fluid be continuous. When salt water is used strong currents may be passed over considerable distances with a very moderate electro-motive force. By using coil currents, which always possess a comparatively high electro-motive force, as much current as a patient can comfortably bear may be passed over many inches of space. Its current-carrying capacity being thus established, we may glance for a moment at its possible therapeutic effects.

It seems not unreasonable to suppose that in the combined electric and hydriatic procedure we may have a therapeutic agent of considerable power. It claims that, according to variations in temperature, force and duration, it may be resorted to as an agent more gentle and adaptable than even the "electric hand" of the physician, or may be made to become so potent and concentrated as to prove a veritable electro-hydriatic moxa. It presents itself as a means of general electrization by bringing the various parts of the body successively under its influence; it claims an action that may be strictly localized; and, further, offers itself as a means of producing, through various motor inhibitory and secretory reflexes, those influences on nervous centres and glands which can undoubtedly be brought about by other and more painful methods of peripheral electrical excitation. If it can establish claims of this kind, a field of usefulness seems to lie before it in a class of cases which readily suggest themselves. (For further details of experiments the reader is referred to Dr. Hedley's complete article in the *Lancet* of Feb. 27, 1892.)

CUPPING IN HICCOUGH.

G. McH., male, aged twenty-one years, native of Brooklyn, was taken suddenly ill in church, February 24th last; had a severe chill which lasted about five minutes. This was repeated in about an hour. On going home he retired, after taking a hot mustard foot-bath and drinking a hot toddy. The chill lasted about an hour this time. A physician was summoned, pending whose arrival the hiccoughing began, and continued incessantly, in spite of the physician's exertions. On the evening of Wednesday, the 27th of February, I was called to attend the case. The hiccoughs (three days and nights in duration) had left the patient, naturally anæmic, very weak; temperature then 104°; pulse, 140 per minute; respiration, short and jerky; dulness on percussion over base of left lung. The patient was in a semi-conscious condition, delirious, picking at the bedclothes, and crouched low down in the bed. A rash, resembling that caused by antipyrine, all over the face and body; marked tympanitic distension of bowels, no passage therefrom in two days. I prescribed one-fifth grain doses of morphia in aqua meth. pip., and aromatic ammonia. After the first dose the distressing complaint stopped, but began again in thirty minutes. Another dose of morphia was given then, as before, stopping the hiccoughs only to have them come on again at intervals of thirty minutes throughout the night. He slept by snatches through the night, as I pushed the morphia. The following morning he was given 1-100 grain nitro-glycerine tablets, one every six hours through the day. This seemed to check the hiccough somewhat, but to no satisfactory extent. I tried nitrite of amyl to relieve the spasm, also made strong pressure on the phrenic nerve at the shoulder-blade—both much vaunted remedies for hiccough—but with no result. On the evening of the 28th of February, I suggested the advisability of a consultation with Prof. Frank E. West, M. D., who met me at the case at 8.30 P. M. He confirmed my diagnosis and sustained my treatment. I then resorted to cupping over the region of the diaphragm, which I continued to apply at intervals of two hours at first, subsequently at intervals of three hours, with wonderful effect. They stopped the hiccoughs. I had to put on about sixty cups. The patient's strength was kept up by small and frequently repeated doses of bovinine and milk, and milk and brandy. He rapidly convalesced. After all antispasmodics failed cupping proved successful.—Dr. Fogarty, in *Brooklyn Med. Jour.*, June, 1892.

PHLEGMASIA DOLENS FOLLOWING INFLUENZA.

Although phlegmasia dolens is a disease which occurs chiefly in the puerperal state, I have seen it lately in three cases of influenza, all of which bore striking resemblance to each other. Instead of the temperature going down, as is usual in an uncomplicated case, it kept up. There was great pain in the groin and upper part of the thigh, quickly followed by swelling, which extended over the whole limb. This rapidly increased, so that in two days the limb was twice as large as the non-affected one. The swelling was of a very solid nature, and did not pit upon pressure. There was not the least alteration by raising the leg. This state of things lasted for ten days, under the usual treatment, when the pain grew less, the limb softer, and the temperature fell to 99·8°. All three patients were affected in the left lower extremity, and were very restless. The obstructed vessels could be easily felt as hard cords. I may mention that the above patients were not subject to varicose veins, and, although married women with families, were never before troubled with their legs. The frequency of phlegmasia dolens in the lying-in period is attributed to the combination

of slowness of the circulation with a varicose condition of the veins *plus* an extra amount of fibrin in the blood. May we not have exactly such a state of things during influenza?—Dr. Ducket, *Lancet.*

Recommendations of Therapeutic Agents.

Europhen in Syphilitic Affections.—Dr. Gaudin (*Jour. des Maladies Cutanees et Syphilitiques*, No. 1892) had made experiments at the Polyclinic of Paris with injections of europhen on syphilitic patients in various stages of the disease, and arrives at the following conclusions: The injections are well borne, although at times somewhat painful. They are never followed by general or local disturbances, but always by an improvement of the syphilitic phenomena. The results were slight in the secondary stage, but always good in tertiary syphilis, especially when the injections were made in the vicinity of the disease. In all of the cases the injections seemed to act as rapidly and efficiently as oleum cinersum or corrosive sublimate. They may therefore be recommended whenever it is desirable to treat rapidly and energetically severe syphilitic phenomena. Gaudin justifies these conclusions on the ground of fifteen cases observed by him. In a sixteenth case of chancroid in the sulcus and in the inner surface of the prepuce, europhen was applied three times daily to the sore, without resort to other medication. In eight to ten days the ulcer had completely cicatrized.

Medical Items.

The Michigan State Medical Society, at its last meeting in Flint, unanimously adopted resolutions urging Congress to pass the Bill creating a Cabinet Officer of Public Health.

The one hundred and seventy-sixth Annual Meeting of the Medical Society of New Jersey will be held at Atlantic City, on the fourth Tuesday in June, 1892, and will continue in session the following day. A special train will leave Camden on Tuesday at 12.15 P. M., for the accommodation of those who wish to attend the meeting. Wm. Pierson, Secretary.

The thirty-fifth Annual Commencement of Rock Hill College will be celebrated at the Academy of Music, Baltimore, Monday, June 20th, at 2.15 P. M., Rt. Rev. Mgr. Edward McColgan presiding. Subjects: Isabella of Castile, Guy W. Steele; Cardinal Manning, Richard R. Davis; Four Centuries of Progress, Elmer M. Harn; Christopher Columbus, valedictory, William E. Talbott; Address, Wm. P. Ryan, A. M., Class of '75.

Dr. G. W. Kaan, in the *Boston Medical and Surgical Journal*, recommends the use of peroxide of hydrogen as a deodorizer in cancer of the uterus, and believes that it exerts some curative action. His method of using it has been to take about an ounce of the peroxide of hydrogen and an equal quantity of water, warmed by being placed in a pan of hot water, and injected through a soft rubber catheter so that the injection shall be sure to reach the back part of the vagina. Such an injection once or twice a day has been sufficient.

At a special meeting of the Board of Trustees of the Medico-Chirurgical College of Philadelphia, Dr. W. Frank Haemlen, Demonstrator of Obstetrics at the University of Pennsylvania, was elected Professor of Obstetrics; Dr. W. Easterly

Ashton, Lecturer on Gynæcology at Jefferson Medical College, Professor of Gynæcology; Dr. Chas. M. Seltzer, Professor of Hygiene; Dr. H. H. Boom, Adjunct Professor of Chemistry; Dr. B. T. Shimwell, Adjunct Professor of Operative Surgery. E. Laplace, M. D., Secretary.

The Fourteenth Annual Congress of the American Laryngological Association will be held June 20th, 21st and 22nd, 1892, at the rooms of the Medical Library Association, 19 Boylston Place, Boston. The profession is cordially invited to attend. A full and interesting programme has been issued. President, S. W. Langmaid, M. D., Boston; Secretary, Charles H. Knight, M. D., 20 W. 31st Street, New York.

The friends and pupils of the late Dr. Samuel D. Gross will receive with pleasure the news of the contemplated monument to be erected to that distinguished surgeon in the city of Washington, D. C. This tribute in honor of the attainments of Dr. Gross has been initiated by the American Surgical Association, and its efforts should receive hearty support from all members of the profession, in which he was such a luminous laborer. Contributions may be sent to Dr. J. B. Roberts, No. 1627 Walnut street, Philadelphia, treasurer of the Association.

The *Med. and Surg. Reporter* announces the following Society meetings for June: June 1st, Ontario Medical Association, at Toronto; 2nd, Oregon State Medical Society, Portland; 2nd, Rhode Island Medical Society, Providence; 2nd, State Medical Society of Arkansas, at Little Rock; 4th, American Academy of Medicine, at Detroit, Mich.; 7th, American Medical Association, at Detroit, Mich.; 7th, Massachusetts Medical Society, at Boston; 8th, South Dakota State Medical Society, at Salem; 14th, Medical Society of Delaware, at Dover; 15th, Minnesota State Medical Society, at St. Paul; 20th, American Association of Andrology and Syphilology at Richfield Springs, N. Y.; 20th, New Hampshire Medical Society, at Concord; 21st, Colorado State Medical Society, at Denver; 28th, Medical Society of New Jersey, at Atlantic City.

Twenty-one nurses were graduated last week from the training school of the Johns Hopkins Hospital. The class formed this year numbers twenty eight. Of the class of seventeen graduated last year, eight have remained in the hospital as head nurses, three have hospital positions elsewhere, three are engaged in private nursing and three are at home. The graduates of last week are Helma Bernard, Minnie James, Adah H. Patterson, Anna C. Jack, Clara E. Worthington, Lucy P. Welch, Estella Hall, Evvy E. Smith, Katherine M. Laing, Marion G. Hemming, Lucy Ashby Sharp, Mary L. Chamberlain, Emily J. McDonnell, Annie C. MacRae, Fanny Priestly Toulmin, Louise K. Rudolph, Mary H. Townsend, Helen B. Higbee, Lilian J. T. Sills, Margaret R. Richardson and Sarah L. Tarleton.

On April 26, 1892, Professor James Tyson presented his resignation as Dean of the Medical Faculty, University of Pennsylvania, to take place with the termination of the business incident to the session of 1891-2. Dr. Tyson, of course, retains the professorship of Clinical Medicine, and hopes through the time gained by retiring from the deanship, to give additional efficiency to this department, as well as to have more time for other work. The trustees accepted with reluctance the resignation, expressing their appreciation of his valuable services in the past, and elected Dr. John Marshall, Assistant Professor of Chemistry, to the post.

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CONTENTS

ORIGINAL ARTICLES.

The Relation of Surgery to the Treatment of Nasal Disease. By George Thomas, A. M., M. D., Baltimore. 727

Report of Case and Exhibition of Specimen of Aneurism of Arch of Aorta. By F. C. Bressler, M. D., Baltimore. 731

Address to the Graduates of the Training School for Nurses, at the University of Maryland. By S. C. Chew, M. D., Baltimore. . . . 732

SOCIETY REPORTS.

Medical and Surgical Society of Baltimore. Stated Meeting held Thursday, Feb. 25, 1892. The Prostate up to Date. Aortic Aneurism. Croup Following Influenza. . . . 734

EDITORIAL.

Albuminuria in its Relations to Surgical Operations. 738

The Thomas Wilson Sanitarium. . . . 739

REVIEWS, BOOKS AND PAMPHLETS. . . . 739

MEDICAL PROGRESS.

Hernia of Lachrymal Gland.—Ureteral Catheter.—A Pastoral Scene, or, New Treatment for Acute Indigestion.—Therapy of Lily of the Valley.—Therapeutic Notes.—Local Examination of Unmarried Women.—On Stammering.—Some Causes of Wakefulness in Infants.—Cancers of the Tongue.—Injections of Gland Matters. 740

MEDICAL ITEMS. 747

Original Articles.

THE RELATION OF SURGERY TO THE TREATMENT OF NASAL DISEASE.*

BY GEORGE THOMAS, A. M., M. D.,

Lecturer on Diseases of Nose, Throat and Chest, College of Physicians and Surgeons of Baltimore.

In presenting the subject of nasal surgery to this Society, it is not my purpose to advance unknown theories, to promulgate hidden secrets of the art, to support or decry acknowledged methods or deliver new ones. My theme leads me over a well-beaten track bearing the impress of the masters of successive ages, and outlined so fully and skilfully, that it is with unfeigned diffidence and apprehension that I venture upon this review. I think I am justified in my effort, however, if for no other reasons than to emphasize the importance of nasal surgery in the great province of medicine, to overcome an apparent indifference and sometimes intolerance on the part of the profession, and to invite liberal consideration of the indications and due appreciation of its valuable results.

All statements, theories and suggestions in every department of medicine should be subjected to calm judicial thought and every available test before the bar of the medical profession. In untrodden paths especially, conservatism and cool deliberation is surely commendable.

Under no circumstances, however, are we, whose function is the preservation of human life and the alleviation of human suffering, justified in sitting listlessly

*Read before the Medical and Chirurgical Faculty of Maryland, April 28, 1892.

with folded hands, and certainly never in ignoring fields teeming with brilliant factors so available and efficient in the discharge of such responsibilities.

Etiology and pathology are the essential basis of all curative therapeutic and surgical indications, and if you will consider the subject from this standpoint the most skeptical will be convinced of the intimate relation of surgery to the treatment of disorders of the upper air passages. Consider for a moment the causation and pathology of hypertrophic rhinitis, the most prevalent form of the so-called "chronic nasal catarrh."

One naturally hesitates to take issue with such careful observers as Lennox Brown, Morell MacKenzie and others whose thought, deductions and methods are the very foundation of our present achievements, and still our guide in many instances, but we are now in a position to refute many of their theories and render obsolete many results of their labors. Taking cold, once deemed the cause, is now considered to be more frequently the result or exacerbation of a chronic process. Climatic conditions unquestionably exercise an unfavorable influence upon its development, but is not the essential factor. Catarrh has been termed an American disease, evidently a misconception based on careless observation and impatient ambition in tracing cause and effect.

In the eager search, tobacco, the dust and fumes of factories and mines, have been challenged also; but I think it can be clearly demonstrated that hey oftener act simply as local irritants, which hasten a morbid process having origin in a pre-existing cause.

Diathetic influences figure largely in the early literature, but I feel assured that the catarrhal diathesis lingers only in the minds of the laity.

It would be a delicate question to decide the influence of the gouty and rheumatic habit. We cannot question, however, the predisposing influence of the more serious dyscrasia, such as the tubercular and scrofulous diathesis.

I believe it is now generally conceded that the most frequent cause of hypertrophic rhinitis is found in the several deformities of the nasal septum, such as deflections, displacement of the triangular cartilage, and irregular alar cartilages, all of which effect more or less mechanical stenosis. One might question the frequency of these disturbances of conformation, but when you consider the prominence of this feature, and its liability to force and pressure, especially in infantile life and childhood, the statement is at once substantiated.

Weakness of the dilator muscles in rare cases has similar effect. Beginning with an obstruction the period of development is variable, and depends upon its extent. The effect of an occlusion is a hypertrophy of the unaffected side in consequence of its increased function and a co-existing increment in nutritive processes. The tissues back of complete obstruction atrophy as the result of abolished function, but in partial stenosis hypertrophy ensues because of the diminished air pressure and the resultant turgescence. Whatever the order of development, we find thickened epithelium, new connective tissue formation, and in certain areas myxomatous transformation. Can there be any reasonable hope of resting tissues from this process, or of restoring the potency of the respiratory tract thus involved, with simple medicated sprays and applications? Obviously we must resort to surgical measures.

Again, in the etiology of hay fever or vaso-motor rhinitis and asthma or vaso-motor bronchitis, we find three essential factors:

1st. Some atmospheric irritant exciting the paroxysms.

2nd. A neurotic habit.

3rd. Some pathological condition of the nose, generally of an obstructive character, attended with vascular dilatation.

The opinion is sustained that they are mutually dependent; and that the first two causes alone cannot operate in establishing the phenomena in question.

The treatment of this third element in the causation of both hay fever and asthma should be the objective point; and since it involves an obstructive lesion we are compelled to resort to either cautery, saw, chisel, snare or refracture. Statistics resulting from this course of treatment verify the conclusion as to etiology and pathology.

Let us consider for a moment the subject of nasal polypus or myxoma, which represents 10 per cent. of all ordinary chronic catarrhal troubles. Here we have to deal with a tumor variable as to number, attachment and structure. The usual type is that of a true myxoma with marked differences attendant on their immediate origin or perhaps on certain adventitious features of their subsequent development or surroundings. They have an epithelial covering enclosing a true hypertrophy of the structures of the mucous membrane, connective tissue, more or less glandular, but no increase of vascular elements. A delicate reticulum of connective tissues, in which is embedded the characteristic stellate myxomatous cells, embryonic connective tissue cells, and an intercellular substance of mucin constitutes the true myxoma.

Because of their limited vascular supply moderate success has followed the application of strong astringents, which effect sloughing and partial separation, but I question the statement of authorities as to complete eradication by this method. The only successful treatment depends upon their complete ablation, and for this purpose we have to resort to the cold steel wire or galvano-cautery snare and forceps. Fortunately fibroma of the nasal passages is comparatively infrequent, but not so rare as thought at one time when the nasal cavity was not subjected to such industrious investigation. This form of neoplasm is found most commonly in the naso-pharynx, but whatever its site, the only indication is removal. Electrolysis may be used to reduce its size, and thus facilitate the adjustment of snare loop. The tumor sometimes develops such grave proportions as to necessitate the invasion of surrounding structures in extirpating it. The great danger in all cases is from hæmorrhage.

We are fortunately not often called upon to deal with osteoma, papilloma, adenoma, cystoma, angioma, chondroma, sarcoma and carcinoma, and I need not suggest that the indications are the same as when they occur elsewhere. You can understand the absurdity of an attempt to check their process and eradicate them by any other method than surgical; as well acknowledge the advice of the extremely practical physician, who suggested the internal administration of chromic acid for softening of the brain, or the cure of physical disease by moral persuasion.

The treatment of syphilis of the nasal passages is variable. The specific treatment, local cleansing and antiseptic applications meet the requirements in primary lesions, coryza or erythema, the superficial ulcers and gummy tumors; but when we have to deal with the mucous patches destruction should be accomplished, and in deep ulcers all necrosed tissues should be removed, in addition to measures, local and internal, just mentioned.

The nose too, like all other structures, sometimes, though rarely, becomes invaded by tubercular processes. Ordinarily we can do little else than cleanse, disinfect and palliate. The neoplastic form, however, demands extirpation where it is feasible, by means of snare, curette, chemical or electro-cautery, the only measures lending the slightest ray of hope. Foreign bodies in the nasal passages and rhinoliths necessitate removal, the latter occasionally reaching such

proportions as to require crushing or an incision into the external nose. Disease of the accessory sinuses are only curable when their cavities can be invaded, direct treatment effected and free drainage established.

I have now given a resumé of those conditions absolutely requiring surgical treatment, and propose to refer briefly to those disorders in rhinology presenting no indications for such radical measures, and in which we are limited to the expectant plan. Purulent rhinitis of children has no assignable cause. It is an active inflammation, extending into the gland structures, characterized by extensive desquamation of epithelium, and a muco-purulent discharge. The treatment is general, hygienic and supporting; and local, cleansing and astringent. Beginning early, the process *can* be checked, and the disease ultimately cured. If we accept, without reservation, Bosworth's theory of the etiology of atrophic rhinitis, so admirably expounded before the International Congress of London, in 1881, we are constrained to rely almost entirely upon cleansing, disinfection and local stimulation. I acknowledge this doctrine to be the rule, but I am convinced that I have seen as exceptions cases illustrating Fränkel's views, who claims that it is a sequence to the hypertrophic stage, or a quasi cirrhotic character following inflammatory thickening. The cases referred to presented bony or cartilaginous obstructions of one, and atrophic rhinitis of the other side. If its origin were in purulent rhinitis, then they should not have been so decidedly unilateral. I have seen marked improvement follow the removal of the obstruction.

Parasites should be dealt with as elsewhere. The subject of nasal hydrorrhœa is still vague and uncertain, the treatment is experimental and largely directed to morbid lesions of the nerve trunk, and to the control of the local vascular turgescence. I hope it will not be inferred that I ignore medication and applications. These measures are invaluable in themselves, and important adjuvants in more radical procedures.

By local anæsthetics, astringents, stimulants, alteratives, antiseptics, deodorizers, cleansing and protectives, we can prevent, abort and hasten resolution in acute disorders; relieve temporarily the local and reflex symptoms of chronic conditions; and add material and indispensable aid to surgery. In conclusion I wish to present the deductions to be drawn from this cursory review of the indications for treatment in nasal disease:

1st. That no diagnosis can be reached, and no course of treatment should be suggested before a thorough examination of the nasal cavity and its accessory sinuses has been made.

2nd. That local medication is never curative in chronic disorders.

3rd. That the same rational principles that lead to the discovery of the cause of disease, its prevention or its removal, should be applied in this department of medicine.

4th. That the cause and essential lesions in chronic nasal disease can only be remedied by surgical treatment.

5th. That nasal disease is as curable as other conditions where surgery is indicated.

6th. That rhinology is distinctly a branch of surgery.

800 Madison Avenue.

The health of Nashville, as shown in the mortuary report for the week ending May 28th, is remarkable for this season of the year, and will compare favorably with that of any city in the United States. Of a population of 100,000, there were only four deaths among the whites and twelve among the negroes. In the latter list was mentioned the death of a man at the age of 108 years.

REPORT OF CASE AND EXHIBITION OF SPECIMEN OF ANEURISM OF ARCH OF AORTA.*

BY F. C. BRESSLER, M. D., BALTIMORE.

This very interesting specimen was obtained from a female, German, aged 46½ years. She had been under my care, off and on, for several years, suffering chiefly from dyspnœa, cough and limited chest movement. I have attended her in several well-marked bronchitic attacks, lasting for a week or ten days. Careful auscultation and percussion failed to find anything except a chronic bronchitis. About a year and a half ago she came to my office suffering with marked pain around the cardiac region, but careful examination again failed to discover anything but bronchial symptoms. Iodide of potassium and morphine were given with relief for some time. I then lost track of her until about three months ago, when I was asked to see her. I found her suffering with marked pain above the heart, also some pain under the left shoulder blade; considerable dyspnœa; cough of a harassing nature; loss of appetite; inability to be about, and almost constantly confined to her bed, with inability to lie on her back; easier while lying on her right side, but best relief when sitting up. Her breathing seemed to be very laborious and cough was attended by a frothy expectoration. She was annoyed by a constant serous dripping from her nose; also a rather free perspiration on forehead. Upon chest found left side decidedly more prominent than right, a swelling extending from lower border of first rib to the fourth, raised about ¾ inch above surrounding area; this swelling was round and highest in the center, tapering towards margin. Whole left side of chest wall pulsated; apex of heart displaced backwards and in axillary region. Upon laying hand on this swelling, obtained expansive pulsations; if pressure with the hand was made this was followed by considerable pain. On auscultating over tumor, heart, along spinal column, under spine of scapula—in fact, anywhere over chest wall—I am not able, upon the most careful auscultation, to obtain a bruit, while lungs give sibilant, sonorous and mucous rales. I not only examined her once, but nearly every time I called, both by stethoscope and direct application of ear to chest. Her breathing was stridulous and attended by spells of apparent collapse, in which attacks patient grew slightly cyanotic, pupils dilated, cold skin, pulse faint, clammy perspiration over whole body, attended by a sensation of fright. No change was observed by compressing both femorals. Radial pulses were weak, almost gone, the left being slightly weaker than the right. Attacks come on in which she cannot swallow, rejecting everything, even water. Gaseous eructation; insomnia; mind clear; passes little water. In this condition she remained nearly to the time of her death.

I might state that a week at least before her death her pectoral pains subsided. A careful examination for tracheal tugging was made, but it could not be gotten.

At her death, the family consented to a post-mortem examination and the following conditions were found:

Uterus normal; bowels normal; stomach normal; spleen enlarged; liver congested; kidneys congested and slightly enlarged; pancreas enlarged and congested; lungs floated in water, crepitated when handled, congested, no consolidation present; both lungs bound to chest wall by old pleurisy; some fluid in pleuritic cavity; pericardium normal; considerable fluid in pericardium; heart hypertrophied; at junction of ascending with transverse portion of aorta, a large, dis-

*Read before the Medical and Surgical Society of Baltimore, February 25, 1892.

tinct globular tumor, size of an ordinary orange, was found, whose anterior wall was thinner than other parts of sac: same anterior portion was adherent to costal cartilages of second, third and fourth ribs, hollowing them out and eroding the cartilage, so as to give it the shape of the aneurism. The interior of the aneurism is filled with both white and red thrombi; on transverse and descending aorta a number of small sacculations are appearing, which in time, no doubt, would have been aneurisms also; the thoracic aorta is cylindrically dilated, forming a cylindrical aneurism and becoming of a normal calibre below diaphragm; here and there the walls of the transverse and descending aorta are lined by a layer of lime deposit, making it keep its lumen open. Upon the pneumogastric on the left side where the recurrent is given off a spot of softening is noticed, which is possibly an old inflammatory lesion. What influence this had upon the various organs it is difficult to say, since the recurrent of the right side was also pressed upon. The specimen here shows this inflammatory condition clearly.

A noteworthy fact is the absence of a bruit, also absence of tracheal tugging. It seems to me that this is a case "par excellence" for the presence of tracheal tugging, since observers have stated that in aneurisms of the arch tugging is gotten when all other symptoms are absent; taking the numerous smaller ones present, it seems strange that it was absent; it therefore must be placed on a par with the other symptoms as not being always present. It is well to remember that in 25 cases of aneurisms observed by Dr. Ross, it was absent in 8 cases and present in 17.

As regards treatment: Surgical treatment was deemed inexpedient, the main reliance being iodide of potassium, given in increasing doses, plus morphia, etc.

1713 Bank Street.

ADDRESS TO THE GRADUATES OF THE TRAINING SCHOOL FOR NURSES, AT THE UNIVERSITY OF MARYLAND.†

BY S. C. CHEW, M. D.,
Professor of Principles and Practice of Medicine, University of Maryland.

Young Ladies, Graduates of the Training School for Nurses:—It is my pleasant duty in the name of the Medical Faculty of the University of Maryland to offer you our cordial congratulations on the success with which you have pursued your studies and the diligence with which you have applied yourselves to your arduous labors. The time has come for awarding to those studies and labors the meed of merit and distinction which they have won.

We welcome you into the ranks of the calling you have chosen as your work in life, a calling the value and importance of which no one can understand so thoroughly or appreciate so highly as physicians. For without the aid of that intelligence and devotion which only the trained nurse can supply, the knowledge and skill of the surgeon or physician may be expended in vain. From the very nature of his business and the constant demands made upon his time by multitudinous cases the physician cannot give a disproportionate share of attention to any one patient, however much his services may be required. It is his duty to ascertain the nature of an ailment, to lay down the course of treatment to be used in combating it, to note the effect of that treatment and to modify it as occasion may demand. But the nurse is always on guard, always watchful and always making practical application of those resources of medical science with which she has been furnished by the doctor. By her careful observation of

†Delivered at the University of Maryland, May 4th, 1892.

pulse, of temperature and of numerous other symptoms, she may save many moments which to the busy practitioner amount in the aggregate to much valuable time; and not only so, but she may keep him apprized of the course and progress of the case, so that he knows it continuously and not intermittingly. Indeed, the sisterhood of nurses may be said to stand to the brotherhood of physicians in the relation which an army of observation and alliance occupies to the main host. You are not members of the medical profession, but you may be its most efficient and important aids. But then remember always that, whatever views may be held as to the wisdom and propriety of admitting women into the medical profession, a question which I do not at all propose to consider here, yet, so long as you are engaged in the vocation of nurses, you are not physicians; nor should you seek to take the place of physicians, however much you may be tempted to do so. Interference in that direction can bring only confusion and trouble, and it is best to keep your allegiance to the physician and to follow the course laid down by him.

On a very remarkable occasion in English history the speaker of the House of Commons is reported to have said that he had "neither eyes nor tongue to see or to say anything save what the House commanded him." In like manner you will find it most in the line of your duty to be only the eyes and tongue and ministering hand of the physician in attendance, and to follow his instructions, however much you may be urged to depart therefrom by importunity, apprehension or distrust on the part of patients or their friends. And when a nurse enters upon the charge of a case of grave disease with this conception of her duty, inspired with loyalty to the physician, striving to aid his endeavors and with ready intelligence to carry out his objects, how different is the sphere of the physician's work from what it is when he has at hand for service only the ignorance, timidity and anxiety of chance assistants, of whom the most inefficient often are the patient's own family. And thus it is that no one is so conscious and appreciative of the good nurse's service as the doctor under whom she serves.

The patient, often far down in the valley of the shadow, may know nothing of the kindly hand that is ministering to him and striving to lead him back to light and life; but the physician knows well the value of that hand to his charge and to himself, and should always be willing to share with the nurse whatever credit may accrue to him when success attends his efforts.

But more than this; when we consider how often in the course of disease other influences may be brought to bear upon it besides mere medical and surgical appliances, how often the wounded spirit, "fast bound in misery and iron," suffers with the suffering body, it is easy to understand how the physician feels most deeply the value of the nurse, not merely as she is a nurse, but because she is a woman. However familiar and even trite the words as we have often heard them may seem, yet how true to our deepest feelings, to our best and tenderest instincts, are those words which say of woman,

"When pain and anguish wring the brow,
A ministering angel thou."

It was perhaps a harsh answer of the doctor of physic in the great drama, who, when asked to "minister to a mind diseased and pluck from the memory a rooted sorrow," could find no other reply than "therein the patient must minister to himself."

Such cases are found outside of dramas and in very real life. There are diseases and wounds of the spirit deeper seated and harder of human cure than any which touch merely the body. And often a sufferer may be helped by the

kindly word, warm from the heart, spoken by the nurse and reminding him of a past when the influence of a mother or sister was around him.

And such is "the better part," that of ministering angels, which you, young ladies, have chosen for your course in life. How could you possibly have chosen a better one? Better by far it is than many of the pleasures and allurements which life may have to offer, but which, after all, are but too often merely the follies and frivolities of Vanity Fair. Your better part it will be to carry help to the suffering, comfort to the sorrowing, deliverance, it may be, and safety to those who are ready to perish.

There was a woman once who will be remembered forever as having chosen that "good part," and as having offered the purest and most perfect act of devotion that this world has ever seen. She was "that Mary which anointed the Lord with ointment and wiped His feet with her hair," and of her it has been said that,

> "One deep love doth supersede
> All other, when her ardent gaze
> Roves from the living brother's face,
> And rests upon the Life indeed."

And so may it be with each one of you, that your service done to the sick, the suffering and the dying, to the failing body or the passing spirit, may raise your thoughts to Him who is the source of all healing and the fountain of all life.

Once more in the name of my colleagues, and for myself, I thank you for the good work you have already done, and I congratulate you on the good part which you have chosen, and which shall not be taken away.

Society Reports.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING HELD THURSDAY, FEBRUARY 25, 1892.

The 737th regular meeting was called to order by the President, Dr. F. C. Bressler. The minutes of the previous meeting were read and approved.

Dr. L. F. Ankrim was elected to fill the office, made vacant by the death of Dr. Norris, of Corresponding Secretary and Treasurer.

Dr. A. Bradley Gaither read a paper entitled THE PROSTATE UP TO DATE. DISCUSSION.

Dr. David Streett: This is the best paper I have heard on this subject, and is of interest to me because of an experience I had about five years ago with a case of prostatitis. None of the causes given by Dr. Gaither could be assigned as a cause in this case. He was not an alcoholic, and had never had gonorrhœa. The only cause that could be assigned was that he was in the habit of sitting on the corner of a chair while writing at his desk, a position he would frequently assume and maintain for several hours at a time. The most distressing symptom was the constant desire to go to stool; the burning pain along the urethra continued from ten days to two weeks. The diagnosis was undoubted, but the cause of the attack was obscure. In speaking of this attack the patient says, "the most distressing period of my life was those three months." The enlarged prostate of old men is frequently overlooked, and this causes distention of the bladder. I have seen several cases where old men complained of pain about the abdomen; they were given opium, and one case was treated for intestinal ob-

struction in good faith. In several cases where I was called I found a tumor in the abdomen, round, pyriform, and when I asked if the urine had been evacuated, I was usually answered in the affirmative. We would catheterize and draw off a large quantity of urine, to the patient's great relief. This can only be due to want of care in examination.

Dr. F. C. Bressler: There is one point that should be borne in mind in these cases, and that is, in catheterizing one should be careful not to empty the bladder too rapidly. I know of a case where the doctor was called on to empty the bladder of a patient, who had been in the hospital for a couple of weeks with a fractured thigh; he drew off a large quantity of urine and turned to empty the basin, and when he turned back to his patient he was dead. I think it a mistake to use metal instruments. I find I am more successful with a soft rubber catheter, and always carry one with me. Some patients will not submit to the catheter treatment, then an operation must be done. Which is the best operation? The supra-pubic operation is generally recognized as the best. In those cases where there is an atrophy or loss of tonicity of the bladder, where the urine only flows, by gravity, through the catheter. Operation is not advisable; the treatment by the catheter is the best treatment in those cases.

Dr. J. F. Martenet: Every doctor comes in contact with some cases. I have not had any cases of acute prostatitis, but have met with several cases of old man's prostatitis. The iodides, as a medicament, are about as good as anything we can use. In a case that was under my observation for about four years before his death, which occurred from some intercurrent trouble, I irrigated his bladder through a funnel, and he learned to do this for himself. When he would have an exacerbation, I packed his rectum with ice, and it gave him relief.

Dr. C. Hampson Jones: I have a case of eight years' duration, which is still under my care. The patient is about 65 years old, and his history is that of gradual enlargement. Five or six years ago there was total inability to pass water without the aid of the catheter. A curious symptom in this case was that about every three months he passed an enormous amount of blood through the catheter—blood in clots, and blood that would clot after being passed. Dr. Michael saw him with me. It was thought that a villous growth caused the hæmorrhage, but an examination negatived that idea. This bleeding has entirely ceased now. Irrigations with boric acid solutions have been of decided benefit in this case. Another case I have, which is not so clear, a man of 35 years, who looks older, is pale and anæmic, says he suffered with congestion of the genitals, and thinks it absolutely essential that he should have an emission once a week, naturally or otherwise, or he will have a nocturnal emission, which he seems to dread. It is these nocturnal emissions that are the peculiar symptom in his case; the emitted material consists of a number of small worm-like bodies that look like casts of the ducts. I have examined it by the microscope for spermatozoa, but found none. I have examined the prostate and I found it was not enlarged or hard. As to instruments, my experience differs from that of the president. I have seen more harm done in the use of the soft catheter than in the use of the metallic instrument. I can call to mind only one case where I could not pass the metallic catheter, and that was where there was considerable deflection of the urethra to the left.

Dr. H. C. Silver: I had a patient some time ago who was suffering from the passage of a calculus down the right ureter. I asked him in regard to his water, and he said yes, he passed it so freely that he sometimes wet the bed. An eminent surgeon was called in as consultant, who treated him for several days by

purgatives and enemas, and the pain continued. We finally catheterized him, and he improved from that time. We used a metal instrument at first, then a soft one, which we taught him to use himself. After a while I was called again, because he could not pass the catheter. I passed a metal instrument, and now he passes the soft catheter again himself.

Dr. Gaither: Usually there is considerable distention before you are called in. You should not empty the bladder entirely. The worse case of hæmorrhage I ever saw was where a distended bladder was emptied too completely. I think it good practice to introduce a small amount of a solution of boric acid, to antagonize the effects of the little of the worst urine that is left in the bladder. As to instruments, in our work at the Johns Hopkins Hospital, we prefer the metal instrument, especially if there is prostatic trouble.

When we are called in to see a man suffering from abdominal pain, it is so popular for us to give him some medicine and keep him in bed until there is an over-distention. I know of a case of a gentleman who was treated in this way; he developed an over-distended bladder and had the usual sequelæ and never has entirely recovered. Whereas had his bladder been emptied at first he would in all probability have made a good recovery.

In the case that Dr. Jones relates, an endoscope would probably reveal a chronic prostatitis, and those worm-like bodies he describes are pus-casts of the prostatic ducts. Iodoform suppositories would be of benefit in this case; he should be carefully watched, as for some reason, which as yet we do not know, iodoform poisoning is apt to be set up more quickly in the rectal use of the drug than in any other way.

On motion of Dr. Streett a vote of thanks was tendered Dr. Gaither for his paper.

Dr. F. C. Bressler related a case of AORTIC ANEURISM, with exhibition of specimen. (See page 731.) DISCUSSION.

Dr. C. Hampson Jones: The specimen is an interesting one, but an early diagnosis is of great importance in these cases. If the diagnosis is made early, then large doses of iodide of potash should be given, and the patient kept absolutely quiet. I have not had any personal experience in treating aneurisms, but Dr. Chambers, who showed a case to the Society some time ago and got most excellent results from this treatment, says, "It is useless to give less than half a drachm of iodide of potash at a dose; it should be given in from half to three or four drachm doses three times a day."

Dr. David Streett related several CASES OF CROUP FOLLOWING INFLUENZA. In a family of six children, all of whom had a mild attack of influenza, five of them had croup, coming on about 12 to 24 hours after the onset of the attack. They all recovered with simple treatment of ipecac and steam in the room. Another case of croup with measles began February 9th; on the 11th the eruption was well marked, on the 13th croup developed; on the 14th discontinued all remedies except quinia for the fever; on the 16th membrane appeared on the tonsils and pharynx, white and distinct. Calomel in 2½ grain doses every hour, given dry on the tongue, until 110 grains were taken; the child is now well except for aphonia; she speaks in a whisper, but the voice is getting stronger. Of the other children in the house, two have taken the measles and have had no throat trouble, so that excludes diphtheria. Another case of a boy three years old with croup, who recovered under the calomel treatment. In these cases I also gave alcohol.

Dr. E. D. Ellis: I have had a similar experience with calomel in the treatment of croup, cases of undoubted laryngeal croup, where there was a distinct membrane; all recovered in about ten days.

Dr. J. F. Martenet: For membranous obstruction in the larynx or pharynx there are many kinds of treatment. I have had eight or ten cases. In my earlier cases I do not remember what I did or did not do, but they all got well. I used papoid in some with good effect. The last case I had I used calomel, one grain every hour, and it got well; the calomel seemed to loosen the membrane and the child coughed it up. A child was brought to the Hopkins Hospital that had a diphtheritic membrane; we did an intubation. The child was only 7 months old, the youngest case that I know of that was intubated. It got well on turpentine 3ss every two hours. There was no strangury in this case. In one case that worried me a good deal at the time, I had tried calomel with Dover's powder, but abandoned it after trying other treatment; I again gave calomel and it cleared up nicely. I intend to use it whenever I get the chance.

Dr. F. C. Bressler: I do not get good results with turpentine in my cases. I find the compound tincture of iodine or iodide of potash gives better results than any other medicine.

1710 W. Fayette St. J. Wm. Funck, M. D., Rec. Sec'y.

CERVICAL DYSMENORRHŒA.

At a recent meeting of the West London Medico-Chirurgical Society Dr. Hanfield Jones read a paper embodying the results of a careful study of several hundred cases of dysmenorrhœa. He pointed out that while many cases came under the head of "neuralgic" and others of "inflammatory" dysmenorrhœa, there remained a large group to which the term "cervical" was most applicable. Numerous cases were quoted to show that uterine retraction did occur in the onset of each menstrual epoch, and that dilatation of the internal os was always present. Though this opening up of the os internum was normally performed without pain, as in the analogous case of labor, yet it was clear that conditions frequently existed which rendered this dilatation painful, and thus gave rise to menstrual suffering. Cases were brought forward to show how uterine displacement, fibroid change, spasm, and hyperæsthesia of nerve endings would all play a part in this process.

The attention of electricians is drawn to a singular accident which occurred in Berlin. An electrical workman, in testing his cells to see if the current was flowing, was in the habit of putting the two ends of the wires in his mouth. He gradually absorbed so much of the soluble salts of copper from the wires as to cause his death. The galvanometer is now substituted in the Berlin workshop for the rough and ready test formerly employed, the danger of which was not before realized.—*Omaha Clinic.*

An Irish high court has decided that injury to a physician resulting in blood-poisoning and death is an accident, so that accident insurance companies are compelled to pay such insurance. Hereafter blood-poisoning from accident will not be repudiated by the accident insurance companies.—*Omaha Clinic.*

The first quarter of the year 1892, in New York State, showed an abnormally high death-roll from local diseases. The Secretary of the State Board of Health, for that State, makes an estimate that not less than 10,000 persons died there, in January, February and March, from epidemic influenza or from disease predicable upon that epidemic.

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BALTIMORE, JUNE 18, 1892.

Editorial.

ALBUMINURIA IN ITS RELATIONS TO SURGICAL OPERATIONS.

As the family physician has often to cast the deciding vote in cases where the advisability of surgical operation is in question, the above subject is quite as interesting to him as to the surgeon. It is with pleasure therefore that we find in the Transactions of the Southern Surgical and Gynæcological Association a very thorough consideration of the matter.

The question was brought before the Association by an able paper from the pen of Dr. J. W. Long, of Randleman, N. C. The author stated: 1st, That he doubted the wisdom of always preferring chloroform in cases where kidney disease was suspected, although in view of public sentiment and the possibility of being held guilty in courts of law in case of fatal results, he always used chloroform in preference to ether in such cases. 2nd, That albuminuria might result from the operation itself, independent of the anæsthesia, either by reflex action or through sepsis. 3rd, That the albuminuric condition always adds something and may add a great deal to the danger of the operation, for the brunt of any shock to the system falls upon the weakest part. 4th, That operation may relieve an albuminuria due to acute affections; but in advanced renal disease no operation ought to be undertaken without a plain statement of the danger incurred. 5th, That neither chloroform nor ether is likely to injure healthy kidneys; and mild recent albuminuria is not a contra-indication to the use of either chloroform or ether. 6th, That operations in certain regions, as the abdominal and genito-urinary, the oral and rectal, are especially liable to cause renal complications and may cause them even when the kidneys are healthy. 7th, That the surgeon ought never to undertake an operation unless the state of the patient's kidneys is known.

In the earnest discussion which ensued, the following points were emphasized: That public opinion will view with more leniency death after ether than

death after chloroform; that a capable anæsthetist ought always to be secured who will use the least possible amount of the anæsthetic; that an hour and a half under anæsthesia would even without operation kill many people, and therefore operations should be as short as possible.

THE THOMAS WILSON SANITARIUM.

The report for the past year of this excellent charity for sick children is before us. Several items are worthy of especial notice. Seven new cottages are to be built during the present year, which will give in 1893 forty rooms for mothers tending their sick children, and eighteen cribs for infants left in the care of the sanitarium staff. The nursing corps is from the training school of the Johns Hopkins Hospital.

It was observed during the past summer that the more feeble patients were much effected by climatic changes; cool and damp weather causing relapses in spite of every precaution. Even the artificial heating of the rooms failed to counteract such influences.

The reaction of the bowel discharges to litmus was found to be about as frequently acid as alkaline. The reaction bore no relation to the severity of the case, and varied in the same case without known cause.

The comparative digestibility and nutritive values of sterilized and fresh raw milk were carefully tested, but no appreciable difference was observed.

The sanitarium was reopened on June 6th, 1892. White children are received from Monday till Thursday; colored children on Friday. The following physicians issue tickets, at the hours named: A. V. Gosweiler, 1300 E. Baltimore St., from 8 to 9 A. M. and 4 to 7 P. M.; N. L. Dashiell, Jr., 700 S. Broadway, from 9 to 10 A. M. and 3 to 4 P. M.; A. Wegefarth, 805 Aisquith St., from 8 to 9 A. M. and 7 to 8 P. M.; J. Wm. Funck, 1710 W. Fayette St., from 8 to 9 A. M. and 7 to 8 P. M.; Anna L. Kuhn, 1224 Light St., from 7 to 8 A. M.; C. Hampson Jones, 25 W. Saratoga St., from 7.30 to 8.30 A. M.

We wish Dr. Booker all success in the interesting, but difficult task which he has undertaken, the investigation and relief of the summer complaints of children.

Reviews, Books and Pamphlets.

Diseases of the Nervous System. By JEROME K. BAUDUY, M. D., LL.D., Professor of Diseases of the Mind and Nervous System, and of Medical Jurisprudence, in the Missouri Medical College, St. Louis, etc. Second edition. In two volumes. Vol. I, 8vo., pp. 350; price, cloth, $3.00. Philadelphia: J. B. Lippincott Co., 1892.

This first volume contains 170 pages on Circulatory Disorders of the Brain, and Meningitis; and 170 pages on Insanity. The material is distributed into 19 "Lectures," the work having originally been founded on class lectures. The second volume will contain Diseases of Brain and Cord, and Functional and Peripheral Affections of the Nervous System. The volume before us is neat and

readable: presenting in simple terms the views of the best specialist workers, as well as the author's own experience. As many physician's libraries lack a special treatise on insanity, this work on nervous diseases (which includes that important subject) is particularly to be recommended to the beginner in practice.

Transactions of the Southern Surgical and Gynecological Association. Volume IV, fourth session, held at Richmond, Va., November 10th and 12th, 1891. Published by the Association. 1892: W. E. B. Davis, M. D., Secretary, Rome, Ga.

This large and handsome octavo volume is an ornament to the valuable series of transactions of this great society of the South. We do not remember to have seen a more creditable representative of American medical progress: and we take pleasure in attesting our sense of the value of its contents by presenting editorial extracts of several of its papers and the ensuing discussions.

Eleventh Annual Report of the State Board of Health of Illinois. With an Appendix containing the Official Register of Physicians and Midwives. 1892. Springfield, Ill., H. W. Rokker, State printer and binder, 1892.

This volume contains a reprint of the Medical Law passed by the Illinois Legislature, and of the Annual Report of the State Board of Health for 1888, the year in which it entered upon its duties as the Medical Examining Board; also a corrected list to 1892, inclusive, of all physicians and midwives licensed by the Board.

An Account of the Influenza as it Appeared in Philadelphia in the Winters of '89–'90, *and of* '91–'92. By J. Howe Adams, M. D., of Philadelphia; reprinted from *Univ. Med. Mag.*, Feb., 1892.

Apparatus for Collecting Water for Bacteriological Examination. By Samuel G. Dixon, M. D., Academy of Natural Sciences, Philadelphia. Reprinted from *Times and Register*, Oct. 24, 1891.

Medical Progress.

HERNIA OF LACHRYMAL GLAND.

In the *Omaha Clinic*, June, 1892, Dr. Panter, of Dorchester, Nebraska, reports the following interesting case: Some time since I was called in consultation by a brother physician to see a little child about two years old, who some days before, while at play in the yard, had been struck by a vicious rooster.

The spur had passed completely through the upper eyelid near the external angular process of the frontal bone, and was followed by a protrusion of the anterior portion of lachrymal gland, which lies against the ocular surface of the eyelids at this point.

Some two or three days had elapsed since the injury before the case came under our observation, and no attempt had been made to cleanse or keep the parts clean in a surgical sense, and disintegration of the protruding mass had already begun.

We were somewhat at a loss as to the best course to pursue, as the condition of the extruded portion of the gland contraindicated its return to its normal condition.

After thinking over the anatomy and physiology of the gland, I reasoned that as it was a gland of the compound racemose variety and its secretion was dis-

charged by a number of ducts, there would still likely remain enough of the gland intact to perform the natural function should the entire portion be excised.

This was accordingly done and the stump left in the wound, adhesions having already taken place about it.

The wound was dressed with antiseptic gauze and collodion dressing, and healed completely in a few days.

I have examined the patient a number of times since discharged, and there is nothing apparent in the eye which would indicate any interference with the function of the lachrymal apparatus.

THE URETERAL CATHETER.

The following article (illustrated) is published by Dr. H. A. Kelly, of Baltimore, in the *Amer. Jour. Obstetrics*, June, 1892:

In spite of my efforts to draw the attention of the gynecological profession to the uses of the ureteral catheter, this valuable instrument does not yet seem to form a part of the regular armamentarium of my fellow-specialists. That there are difficulties in the way of its employment I readily acknowledge. It is a delicate instrument, requiring practice and tact for its successful use. An amateur cannot be shown how to use it with the same facility as the Sims speculum or the uterine sound, and even with the greatest skill success is not always the rule.

These difficulties one would think would, however, only prove incentives to the acquirement of that practised manipulation which promises its possessor so much. The acquisition of the skill necessary to introduce a catheter into the ureter, on the part of gynecologists in general, would just as surely entail the conquest of the field of renal and ureteral pathology as a part and parcel of the gynecological field.

I will not here again dwell upon the numerous and important differentiations between bladder and kidney, and between right and left kidney diseases, thus to be made, but speak simply of a few improvements which I have made in Pawlik's valuable instrument, securing finally what I believe to be a perfectly satisfactory ureteral catheter.

The catheter thus made is a slender metal tube, 30 centimetres in length and 2 millimetres in diameter. At the end which is introduced into the ureter it is slightly curved for 2 centimeters, and terminates in an olive-shaped point 1½ millimetres in diameter. Any farther diminution of the size of this point renders it liable to pierce the bladder in the attempt to catheterize the ureter, while if it is larger, it it difficult to introduce into the ureteral opening.

I found that the long slit of Pawlik's catheter, which lets the urine into the catheter, would frequently catch and cut the mucous membrane of the urethra as was being carried into the bladder; I have replaced this in my own instrument by several perforations in a little gutter countersunk on the concave side of the shaft near the point of the instrument. The opposite end of the catheter at the handle is provided with a lip curving downward to facilitate the discharge and collection of urine in a finely graduated tube. During the introduction of the catheter this end of the tube is plugged with a short metal rod, otherwise the urine would continually escape from the bladder while the orifice of the ureter was being sought. This little rod is attached by a fine chain to the catheter to prevent its being lost. I have placed a fixed metal handle four centimetres from the end of the instrument, six centimetres in circumference, and flattened on the side toward which the point is directed. This enables one to conveniently

hold and direct the instrument in its introduction, and is better than the split movable wooden handle previously in use.

The catheter thus constructed is altogether a convenient instrument, and its introduction one of the most delicately pleasing gynecological manipulations. I often thus introduce two catheters at the same time—one into each ureter—when, by hanging a little test tube on the end of each, urine is simultaneously collected from both kidneys.

The figures show the last case thus catheterized in the Johns Hopkins Hospital. In one a single catheter is introduced: in the other both are draining the kidneys through the ureters simultaneously. The angle between the two is 59°.

The catheter here described is made by Mr. Willms, of Baltimore.

A PASTORAL SCENE, OR NEW TREATMENT FOR ACUTE INDIGESTION.

She was a bashful young girl. The doctor was yet a modest young man—enviable qualities of character—stereotyped virtues! Her mother was a staid, circumspect and considerate woman of forty or more winters. The home was six miles in the country, a log house relieved by a middle door, two windows and a porch in front. It was roasting-ear time, cucumbers and green fruits were in season and somebody had to be sick, for the young doctor was discouraged almost to desperation for the want of his first patient and a chance to try his hand.

But before the doctor reached his patient she had been poulticed, peppered, and spiced—had been bathed, gingered, turpentined, and oiled. The "poor thing" had suffered, squirmed, twisted, bent double, straightened out, and made wry faces until it was thought useless to try to get her to swallow any more "medicine truck." The doctor, gathering up his wits, thought of cataplasms, cups, blisters, phlebotomy, but there was no time nor space for either of these. Her contortions and groaning were like the perpetual motion of unrestrained caterwauling, only the cats were all frightened from the mansion. Fido, the little dog, was safe only under grandma's chair, and the old dog only dared to peep in at the back door, with a low, plaintive whine. The chickens were cackling, but the cows had gone to the pasture in the back fields. In utter confusion, if not despair, the young mediciner opened his pill-bags, hoping the sight of labels might suggest some remedy. Emetics, cathartics, antispasmodics, anæsthetics, anthelmintics, carminatives, etc. etc., but the patient had no time to swallow any of these. What must be done? What can be done? Ah! there is Davidson's syringe, the best squirt-gun in the world; and if, when a boy, the doctor could have had such a play-thing he would have entertained the whole neighborhood. This suggested the very thing for the occasion—a clyster—but then who would administer it to the young lady! The doctor contemplated quitting the profession right then and there. "But," said he to himself, "I'll mix it and the mother must do the rest. It must be done." A wash-bowl with a pint of warm water was ordered, to which was added castor oil for the cathartic, turpentine for the diuretic, assafœtida for the anti-spasmodic, ol. chenopodii for the anthelmintic, laudanum for the narcotic, mustard for the emetic, and a little salt, red pepper and coal oil for cross-firing. "There, stir up well, and you know how to use this instrument, don't you, Mrs—?" "Oh, yes." "Well, administer it right away," was the order, the doctor withdrawing from the room. While sitting on the porch, leisurely contemplating what could be tried next if this should fail, the mother suddenly looked out of the window, saying, "Doctor, it is so nasty—must she drink it all?" The emetic effect of the clyster was most gratifying.—Dr. Tadlock, *Nashville Journal of Medicine and Surgery*.

THE THERAPY OF LILY OF THE VALLEY.

In the *Canadian Practitioner*, June, 1892, we are told that: The preparation of convallaria majalis that should be employed is an alcoholic tincture of the flowers, 4 oz. of flowers to the pint of dilute alcohol, in doses of 20 to 30 m.; or the fluid extract of the flowers, that made by Parke, Davis & Co., of Detroit, being hitherto most reliable, given in doses of 5 drops three times a day up to 20 or 30 m. ever four hours or more. Other preparations are fluid extract of the herb and fluid extract of the root, not likely to be of such service for the reason given above; pill of convallamarin $\frac{1}{2}$ gr., and tablet triturate convallamarin. $\frac{1}{60}$ gr.

Points of interest in its dosage are that it has no cumulative effect, and that smaller doses, of the size stated above, have vascular and cardiac sedative and diuretic effects quite equal to those of much larger doses, even half a fluid ounce at a time. It is to be noted, too, that idiosyncrasy is to be guarded against, small initial doses being employed.

According to Sée the therapeutic indications are summed up as follows:

"(*a*) In palpitation resulting from exhaustion of the pneumogastric nerves (cardiac paresis), the most frequent source of palpitations.

"(*b*) In simple cardiac arrhythmia, with or without hypertrophy, with or without lesions of the orifices or valves.

"(*c*) In mitral constriction, especially when it is accompanied by failure of compensation on the part of the left auricle and right ventricle; the contractile force augments visibly under the convallaria, as the sphygmograph testifies.

"(*d*) In mitral insufficiency, especially where there are pulmonary congestions, and when, as a consequence, there is dyspnœa, with or without nervous trouble of the respiratory apparatus.

"(*e*) In Corrigan's disease the peripheral arterial pulsations disappear, and respiration becomes markedly restored. In dilatation of the left ventricle without compensatory hypertrophy it restores energy to the heart, which tends to become more and more feeble and dilated.

"(*f*) In dilatations of the heart, with or without hypertrophy, with or without fatty degeneration, with or without sclerosis of the muscular tissue, the indications for convallaria are clear.

"(*g*) In all cardiac affections indifferently, from the moment that watery infiltrations appear, the drug has an action evident, prompt and certain.

"(*h*) In lesions with dyspnœa the effect is less marked. To combat cardiac dyspnœa, convallaria is inferior to morphine, and especially to iodine, but morphia suppresses the urine, and iodine is in every way preferable. The combination of iodide of potassium with convallaria in the treatment of cardiac asthma constitutes one of the most useful methods of treatment. Finally, in cardiopathies with dropsy, the convallaria surpasses all other remedies. One is often obliged to suspend the use of digitalis on account of vomiting, digestive disturbances, cerebral excitation, the dilatation of the pupil which it so often produces after prolonged uses. The final action of digitalis is exhaustion of the heart, increase with enfeeblement of the heart's pulsations, just the opposite effect from those we seek when we give the drug.

"Convallaria has no deleterious influence on the economy and no cumulative action."

THERAPEUTIC NOTES.

The tincture of iodine is best used as a local application, when mixed with glycerine. The skin remains soft and is in a better condition for absorbing the drug.

To deodorize iodoform use one part of carbolic acid; two parts of oil of peppermint; and one hundred and ninety-seven parts of iodoform.

In eighty cases of whooping-cough, antipyrin was beneficial in four-fifths of the number. As many decigrammes were given night and morning as the child was years of age.

In eczema after the acute stage has passed, arsenic is a most important remedy. Give the arseniate of soda in one-tenth (?) of a grain doses, once daily.

In uterine hæmorrhage, the Berlin clinics report extensive use of hydrastine. It is given in capsules, in three-eighth grain doses, four times daily. It acts upon the small vessels of the mucosa; and, therefore, is not indicated in post-partum hæmorrhage, or hæmorrhage from abortion.

In severe cases of metrorrhagia, Dr. J. W. Johnston, of W. Va., reports he often failed in giving relief until he tried ergotole. He gives 15 to 20 drops every two hours until hæmorrhage ceases.

To remove foreign bodies, such as pieces of meat, from the throat, blow forcibly into the ear. Powerful reflex action is excited, when the foreign body will be expelled from the trachea.—From *Nat. Med. Rev.*

THE LOCAL EXAMINATION OF UNMARRIED WOMEN.

Commenting favorably on the excellent article of Dr. Coe (*Med. and Surg. Reporter*), the editor of *Gaillard's Medical Journal* says:

"In the discussion of a recent able paper of Dr. A. Jacobus on amenorrhœa before the North-western Medical and Surgical Society, the consensus of opinion seemed to be that local treatment was unavailing in most cases, and several able observers inveighed against the too common practice of vaginal examination of young girls.

"The writer's personal observation may serve to enforce this view. He has occasion to treat a large number of young lady teachers. Recently two of these have consulted him who have been treated by "lady physicians." It appears from their statement that many of their friends have been subjected like themselves to tri-weekly applications of tampons, iodine, pessaries, etc. In both cases there was no organic disease requiring local treatment. One had become a utero-maniac whose chief symptom was vomiting and loss of appetite. Placing her under strict surveillance in the hospital and giving her daily cold ablutions, with tonics and absolute abstention from local treatment, restored the stomach. She gained flesh and went to work. But her utero-mania had been so firmly established that she applied at a dispensary, where the young gynecologists treat her anteflexure secundem artem (?). The other case was found to be suffering from constipative anæmia and neurasthenia. Being a woman of great will power she has abandoned all thought of local treatment, and is now gaining health and strength under the rainbath, and daily ablutions, aloes and mast pills, and good diet.

"It is our duty to save these young girls the mortification and annoyance, and and absolute injury of a vaginal examination unless found absolutely necessary, after failure of other treatment. To our colleagues of the gentle sex this duty is quite as imperative, and their attention to it is the more necessary since they may regard the moral effect less pronounced, and many of them deem themselves specially adapted to this class of practice among young women."

ON STAMMERING.

In studying the phenomena of stammering, three general causes are found:

(*a*) Faults in the local mechanism, by which term is meant not only the larynx, but also the lungs and muscles of respiration.

1, Want of promptitude in the supply of voice during the pronunciation of the initial syllable.

2, The voice may not only lag, but may also be feeble in quantity, because the speaker does not fill the lungs with air, but attempts to speak from a half empty chest.

3, The voice sometimes breaks from its natural pitch during a struggle in speech and assumes a much higher key.

4, There may be a drawback phonation, the result of an attempt to speak during an inspirating effort.

(*b*) Faults in the oral mechanism, caused by surcharge of energy.

1, The lagging of the voice and misdirection of energy cause the stammerer to surcharge his oral mechanism with energy so that he sticks at his explosives and prolongs his fricatives and nasal resonants.

2, From the nerve-centres of oral articulation thus surcharged, an overflow in some cases occurs, producing spasmodic movements in the face and sometimes in other parts of the body. The most common of these are spasmodic twitching of the lips and cheeks, working of the jaw, and forcible winking of the eyes.

(*c*) Overflow into the upper glottis. In a few cases, the energy imperfectly supplied to the vocal mechanism flows excessively, not only into the organs of articulation, but also into the upper or non-vocal parts of the larynx. This part has the false cords for its inferior margin, which is unclosed during phonation. If, however, the false cords close over the true and shut off the passage of air by their valvular action, the voice is at once interrupted and the patient, with open mouth and congested face, silently struggles without being able to emit the imprisoned air.

In beginning treatment it is best to first explain clearly to the patient the nature of his defect, and to show him that it is not the mouth, but the larynx that is at fault. He must therefore attend only to the voice and speak in a full, resonant, but natural tone. He should practise reading aloud, at first poetry, then prose. If he has an ear for music, he should cultivate the voice in song. He should be taught the physiological alphabet, for which complete instructions are given by the author. He must be taught to fill the chest with air, but if he grasps the great principle of speaking with voice he does this instinctively. Extreme cases require the instruction of a specialist, but, as a rule, persevering and intelligent practice will enable the patient to effect a cure for himself.

The prognosis depends largely upon the intelligence of the patient. Age is an important factor, being favorable between twelve and sixteen. Cases with severe spasmodic complications are unsatisfactory.—Dr. Wyllie, in *Edinburgh Medical Journal.*

SOME CAUSES OF WAKEFULNESS IN INFANTS.

From an article by Dr. J. L. Minot, of Memphis, Tenn., in the *Massachusetts Med. Jour.*, June, 1893, we clip two paragraphs:

Cold feet are not unfrequent cause of wakefulness in infants. Delicate infants, in whom the circulation is languid, are very subject to coldness of the extremities: and griping pains in the belly are common accompaniments of the same conditions. In all cases of abdominal pain in infants the feet should be examined. When these are found to be cold, warming them by friction with the hand, or by hot applications usually causes the manifestations of pain to cease. The feet in infants should be always carefully warmed before the children are put to bed;

and should, in cold weather, be afterwards wrapped in flannel, or be covered with thick woolen socks.

Worms, in older children, are well known to be a common cause of night terrors and restlessness; but even in infants, crying at nights is sometimes found to be due to this cause. Amongst the poorer classes, where infants are allowed early to share in their parents' meals, it is not so very uncommon to find them suffering from the presence of oxyuris vermicularis. To give one instance out of many which have lately come under my notice: A child of nineteen months, well nourished, strong on his legs, who had walked from the age of ten months, had cut teeth regularly, and could talk, the mother said, well, was brought for fits of violent screaming, which began about 8 P. M. and lasted the greater part of the night. From the condition of the tongue, etc., worms were suspected, and a purgative brought away a large quantity of the small thread-worms. A careful regulation of the diet, and the administration of a decoction of aloes by enema soon gives relief. The night-screaming ceased from the very commencement of the treatment.

CANCERS OF THE TONGUE.

In closing a paper upon this subject before the American Surgical Association, Dr. Dandridge, of Cincinnati (*Jour. Amer. Med. Asso.*, June 11), considered the following conclusions justified:

1. Sufficient experience has been accumulated to show that the removal of cancer of the tongue prolongs life and adds to the comfort of the patient and further affords a reasonable hope of permanent cure.

2. All operations should be preceded by an effort to secure thorough disinfection of the mouth and teeth.

3. In the treatment of continued ulcers and sores on the tongue, caustics are to be avoided and all sources of irritation removed.

4. Persistent sores on the tongue should be freely removed by knife or scissors if they resist treatment.

5. When the disease is confined to the tongue, Whitehead's operation should be employed for its removal.

6. In this operation, the advantage of preliminary ligation of the lingual artery is not definitely settled, but the weight of authority is against its necessity.

7. The advantage of leaving one half the tongue in unilateral disease must be considered undetermined, but the weight of positive experience is in its favor. In splitting the tongue into lateral halves, Baker's method of tearing through the raphe should always be employed.

8. A preliminary tracheotomy adds an unnecessary element of danger in the removal of the tongue in ordinary cases.

9. When the floor of the mouth has become involved or the glands are enlarged Kocher's operation should be employed, omitting the spray and preliminary tracheotomy.

10. Removal of the glands by a separate incision after the removal of the tongue must be considered sufficient.

11. Volkmann's method still rests on individual experience. Its just value can not be determined until it has been subjected to trial by a number of surgeons.

12. Thorough and complete removal should be the aim of all operations, whether for limited or extensive disease.

13. By whatever method the tongue is removed, the patient should be up and out of bed at the earliest possible moment, and should be generously fed.

INJECTIONS OF GLAND MATTERS.

"It is evident that some great truth lies behind these words, and that all the tissues of the body give something special to the circulating torrent. If this can be defined, there is a new therapeutical method, or a number of them, based on these facts, to be given to the world. If all tissues, glands, and other organs have an internal secretion which they give to the blood, and which has a favorable influence on normal health, keeping the organism in a proper equilibrium, and if morbid manifestations depend on a want of these principles, then it is but natural to conclude that the injection of such liquids (taken from a healthy animal) would supply the want caused by disease. So far it has not been found possible to use all these fluids, owing to their poisonous effect upon the human subject, but M. D'Arsonval has found they can be sterilized by a simple method, as follows: A healthy animal is chosen (a guinea pig by preference), and the tissue or gland taken from it and cut into very small pieces. It is then macerated for twenty-four hours in three times its weight of glycerin (that has been boiled). Then three times the volume of boiled water is added, when it is all put in a chamois-leather filter and drawn off by aspiration, submitted to a temperature of 40° C., and then sterilized by carbonic acid gas that is under pressure. (This liquefied gas is kept in iron tubes in the same way as the dentists keep nitrous oxide gas.)

"The new therapeutical method being one of injection of *all the tissues and glands of the body*, it would seem to follow that in leucocythæmia we should use the fluid of the lymphatic glands, in anæmia that of the spleen, bone-marrow, etc., and in muscular weakness that from the muscular tissues. The nervous diseases must be treated by the fluid extracted from the nerves and the great central organ, the brain, as well as perhaps the testicular fluids; in diabetes, the pancreatic fluid; while the stomach complaints we shall improve on acids and pepsins. In Addison's disease the fluid of the suprarenal capsules should be employed, and in myxœdema the thyroid gland, and so on. This is no fancy picture, but a truth that will be demonstrated before many years.

"Dr. Brown-Séquard is about to publish a large book, giving the results of the past few years' experiments upon the cure of locomotor ataxia, nervous diseases, and the *weakness due to old age.*"—*Ex.*

If this homœopathic method is to be the next fad, the brains of the common ass ought soon be at a premium.

Medical Items.

We learn with pleasure that the physicians of Wicomico county are about to assemble in Salisbury, Md., in order to form a county medical society. Which of our other counties will wake up next?

A carriage insurance company has just been organized in London for indemnifying owners of horses and vehicles against injury to persons and damage to property. It is called the "Vehicular Insurance Company."

The Grady Hospital, which was erected as a memorial to Henry W. Grady, was opened in Atlanta, Georgia, last week. The city appropriated $15,000, the rest was raised by private subscription.

A single child sent to school before complete recovery from scarlet fever in one of the arrondissements of Paris, was clearly shown to have been the direct cause of a hundred and fifty other cases of that disease, with eighteen deaths.—*Med. Rec.*

At the recent commencement of the Training School for Nurses of the University of Maryland Medical School the nurses graduated were: Anna Edith Lee, Anna Louise Schlennes, Amelia Neil, Leila Dunham, Mary Elizabeth Goldsborough, Catherine Crane Lucas, Janet Hale and Edna Dunham. The address delivered by Dr. Chew on that occasion is presented to our readers in a preceding column of this issue.

Dr. Lewald, in "Der Irrenfreund," says that as a sedative in mental diseases duboisinum sulfuricum has no superior. He has used it in a large number of cases, and finds that its hypnotic influence can be depended upon. It is to be administered subcutaneously, in doses of not more than 0.002 gr., and it is in no case to be increased. The author thought that if the drug were more widely known, the time would not be long before it would supersede hyoscine, as it was more effective and possessed less disagreeable properties.—*Jour. of Nervous and Mental Diseases.*

The *Chicago Times* has lately printed a report of the state of the lake which is discouraging. The flow into the lake of the Chicago River is about 400,000 cubic feet a minute. The water from this river is black and bad smelling and contains much of the sewage of the city. The influence of this flow is seen in the lake almost as far down as the crib from which the water-supply is taken. If the river continues to flow into the lake, it will in time be dangerous to take water from the lake even at several miles distance. The one safety is in creating constant flow from the lake through the river to the Mississippi basin. With the exception of a ridge of land eight miles west of the city, there is a gradual drop down to all of the tributaries of the Mississippi River.

Concerning compulsory insurance in Germany, Dr. Wilhelm Bode has contributed an article to a contemporary on the German National Insurance Scheme, from which the *Insurance Record* quotes the following pithy comments: "We are sick of the insurance laws. I mean that the majority of Germans would give much to get rid of them in a decent way; but, unhappily, there is no decent way, for a simple repeal is scarcely possible, because the laws have created millions of claims, and it is only natural that our politicians do not like to confess before the whole world that they have been fools, and that this grand German work of social reform, which we praised so loudly as a model for all the nations, was only a great mistake. As for the first two laws, insuring against accident and sickness, it is believed that the single fact of the simulation which they provoke is enough to condemn them. If 5 per cent., or even more, of all the cases are frauds (sometimes to 25 per cent.) that does not make a compulsory insurance popular."—*Baltimore Underwriter.*

The second meeting of the International Dermatological Congress will be held in Vienna from the 5th to the 10th of September, 1892. Many of the most distinguished representatives of dermatology and syphilography from all countries have promised to present papers and the indications are that the meeting will be a great success from a scientific standpoint. The committee on organization, through the president, Prof. Kaposi, has extended a cordial invitation to the members of the American Dermatological Association and of the New York Dermatological Society and others interested in dermatology in this country to be present. The membership fee (five dollars) should be sent with titles of papers intended for presentation to the Secretary for North America, Dr. Prince A. Morrow, 66 West 40th Street, New York, or to the Secretary-General of the Congress, Dr. Gustav Riehl, Wien 1-20, Bellaria Strasse 12.

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CONTENTS

ORIGINAL ARTICLES.

Meningitis in Children. By Charles O'Donovan, M. D., of Baltimore. 749

The Symptoms and Treatment of Neurasthenia. By G. H. Greely, M. D., Baltimore. . . 758

EDITORIAL.

Venomous Snakes of the United States. . . 760

A Co operative Summer Resort. . . . 761

Heat-Stroke in Children. 761

REVIEWS, BOOKS AND PAMPHLETS. . . . 762

MEDICAL PROGRESS.

Causation of Typhoid Fever.—Unjust Health Laws in Chicago.—Oxygen Inhalations.—Effect of Pneumonia on the Kidneys.—The Best Nutritive Enema.—Arrest and Trial of a Traveling Medicine Man.—Treatment of Ante-Partum Hæmorrhage.—Treatment of Pleuritic Effusion.—Pulmonary Atelectasis as a Cause of Anæmia.—Camphoid: A New Substitute for Collodion for Medical Use.—New Method of Examining Specimens of Blood.—Catarrhal Laryngitis of Bicyclists. 763

MEDICAL ITEMS. 769

Original Articles.

MENINGITIS IN CHILDREN.

BY CHARLES O'DONOVAN, M. D., OF BALTIMORE.

Definition.—When Dr. Whytt, of Edinburgh, in 1768 wrote his classic work on this subject, he designated this disease "acute hydrocephalus" from the occurrence of serous effusion in the ventricles, and those who followed him continued this name; even Watson, in 1836, lectured on acute hydrocephalus, but said, "I think hydrocephalus a bad name; because it reminds one of only one circumstance of the malady, viz., the serous effusion, which, far from being the cause, or the essence, is only a frequent effect of the disease." He defines hydrocephalus as "inflammation of the brain, as it frequently occurs in children, and especially in scrofulous children," thus indicating the divisions made later on of simple and tubercular meningitis.

In tracing this disease through the writings of later authors one is apt to become more and more confused by the divisions of meningitis according to which membrane is involved, whether arachnoid or pia mater, and also by the differentiation of meningitis of the base of the brain from that of the convexity; so that I have determined for sake of simplicity, as these differences belong rather to refinements of pathological anatomy than to the province of clinicians, to rest content with the general division of meningitis into simple and tubercular. Whether or not this is the final classification of this disease, we can only speculate; for while it was supposed a few years ago to cover the ground completely, the field has lately been ploughed up by the bacteriologist, who has found, in the mem-

branes of those ill with meningitis, various micro-organisms not formerly known, always some form of diplococcus. Very noticeable and very instructive is the frequent presence of the pneumococcus, explaining perhaps the brain symptoms nearly always complicating pneumonia in children. Their studies have not yet advanced far enough to justify us in giving up the old classification. Their work may, however, help to clear up the distinction between simple and tubercular meningitis, which I consider very hazy. A. Jacobi, in Keating's Cyclopedia of Diseases of Children, indicates the general clinical differentiation by the careful comparison of the symptoms in aggregation, and Rosenthal, of Vienna (Diseases of the Nervous System), goes over the ground quite thoroughly. So that a difference exists must be admitted, and should be carefully studied in each case, as the prognosis rests substantially upon its recognition.

Occurrence.—It is generally admitted that of the two varieties, while either may occur at any age, simple meningitis is more frequent under two years, from which time until puberty the tubercular form predominates. Lewis Smith goes over this ground in his book quite fully, and describes five post-mortems, seen by himself, of children that had died of tubercular meningitis, under the age of one year. European authorities speak of it as rare under two years.

There is a diversity of opinion about the occurrence of idiopathic simple meningitis in children; Dr. Wm. T. Howard, of Baltimore, states positively that he never saw a case, and several prominent physicians, whom he quoted in conversation with me, have had similar experience. Lewis Smith says that it does sometimes occur. Rosenthal says, "Simple primary meningitis follows cerebral irritation and concussion," but this refers to all ages; and also that "meningitis sometimes complicates other inflammatory diseases, such as bronchitis, pneumonia, pleurisy, pericarditis, acute exanthemata, erysipelas and acute articular rheumatism, and may appear in the course of Bright's disease, pyæmia, endocarditis, puerperal diseases, phlebitis, typhoid fever, dysentery and carcinoma." These do not all affect children, but the classification is valuable. Lewis Smith says, "The causes of simple meningitis are not fully ascertained," and mentions severe bronchitis, the disappearance of scalp eruptions, insolation and excessive atmospheric heat, and otitis media.

Watson says, "Whatever tends to deepen and aggravate the scrofulous diathesis may be regarded as a predisposing cause of acute hydrocephalus. And whatever tends to call scrofulous disease into action may be reckoned among its exciting causes:" and he mentions the disappearance of scalp eruptions, painful dentition, violent exercise, blows on the head, falls, severe pain, violent anger and fright.

Ramskill, in Reynold's System of Medicine, discusses quite fully the connection of meningitis and acute rheumatism—more thoroughly than most other writers, who mention it, however. When we consider that the meninges are prone to inflammation under such varied stimuli it would appear that some exciting causes might be found by careful search to account for each case: any shock or unbalancing of the nice adjustment of the normal intra-cranial condition being sufficient to set up inflammation of the delicate membranes.

Tubercular meningitis is due to the transplantation of the bacillus to the meninges, where it proliferates rapidly.

Symptoms.—The onset of tubercular meningitis is usually very slow, beginning with fretfulness and an abnormal amount of temper in the child, with little or no elevation of temperature, and slightly slower pulse than normal. It will not be amused by its usual course of play; if apparently happy, it will suddenly

drop all toys and begin to complain in an indefinite way of something wrong, to return again after a few moments to its playthings. This may occur a number of times during the day. The first definite symptom is usually constipation, though diarrhœa is sometimes present, but obstinate constipation, with more or less pain in various changing spots in the abdomen, is the chief factor before the head symptoms are developed. The appetite is capricious, and varies with the child's moods, being ravenous at times, while at others it refuses food. Thirst is usually pronounced, especially if there is some fever present. If the child has any rheumatic tendency, it will be apt to complain of severe pains in the joints and muscles of the extremities, whether at rest or in motion. This is so severe in many cases that a species of rheumatic meningitis is recognized by most authors. At about the third day of recognizable illness, vomiting usually appears, and this is often the symptom which first directs one's attention to the head as the true seat of the trouble. There is something peculiar about the vomiting of meningitis that cannot be forgotten; there is no effort with it; no straining, no retching; the child, usually after eating or drinking heartily, sits up in bed, opens its mouth and pours out a cascade of fluid in surprising quantity. I have seen a child cry and fight for water so violently that the attendants would give it all that it wanted from fear of exciting convulsion, only to see it regurgitated after a few moments, and almost at once the same appeal for fluid begin again. Usually when a child vomits it cries or strains; the act of vomiting seems to be disagreeable, but in meningitis it comes on as a matter of course, and excites no comment on the part of the patient. This peculiar vomiting is ascribed to the disturbance of pneumogastric nerve function, and is thought to be pathognomonic of basilar meningitis. About this time drowsiness and photophobia begin to be noticed, the child lying quiet in the intervals between the periods of excitement. If roused it is perfectly rational, and answers readily and correctly, but will often express anger at the questioner, or will refuse to talk at all. Irritability is much increased and easily aroused. The mind wanders to many things; if anything pleases the fancy of the patient he wants it, and wants it at once; any delay in carrying out the imperious commands is followed by a paroxysm of violent rage. Headache becomes a prominent symptom now, constantly present, frequently complained of, especially after a fit of anger, when it becomes intense. Often it is located in a certain definite spot, sometimes it is more general. Gradually it grows worse as the disease progresses until it becomes the most prominent symptom, occasioning low moans of pain, or violent shrieks as it seems to vary in intensity; frequently it is so severe that the child is waked by it from quiet sleep, and starts up with a piercing cry of "Oh, my head! Oh, my head!" gradually dropping off again into sleep or stupor. The nurse will be ordered to rub the head, which seems to soothe for a time, perhaps inducing sleep; at another time, after a few moments of quiet, even the touch of the hand irritates and gives rise to a paroxysm of anger.

By this time the capricious changes in the pulse-rate peculiar to this disease will have been noticed; from a rate somewhat rapid in the commencement, it falls below the normal as the brain becomes more involved, and usually does not become frequent until near the end of the disease, when it runs up very quickly; but there are variations in the character of the pulse that are noticeable: it is irregular, and varies in tone, being often very weak, and changing within a few minutes to a fair strength, it often intermits after six or eight beats and again runs regularly; any exertion will accelerate it. The temperature of tubercular meningitis is variable; Jacobi says, "It is not typical, and has no regular course."

The skin is often hot, at other times cool and pleasant; sometimes these changes follow each other rapidly and for no appreciable cause, or some portions of the body may be hot and others cool; this is so apparent that it is often remarked by the attendants. A diffused redness of the surface often spreads over one cheek or a part of the face, and disappears suddenly, to reappear in another spot, showing disturbance of vascular nervous control. And it may be well to refer here to Trousseau's "tache," the streak of red slowly forming in the skin, over which the end of the finger has been rapidly drawn with some little force, a faint blush at first, slowly becoming red, remaining a few minutes and slowly disappearing. At present little reliance is placed on this as a diagnostic mark of tubercular meningitis, as it is known to occur in other diseases; formerly it was spoken of as diagnostic.

The constipation, which is so obstinate in the beginning of the attack, does not continue throughout its course; in fact, a diarrhœa is sometimes set up by the purgatives that must be used in combating it, and in the stage of coma involuntary relaxation of both sphincters is a common occurrence.

Another abdominal symptom is the boat-shaped belly caused by retraction of the anterior walls, which is described by all authorities as a diagnostic mark; Jacobi excepts from its universality very young infants. Some authors attribute it to muscular action, while others think it the effect of intestinal collapse. Smith says of it: "The anterior abdominal wall approaches the spine, so that the pulsations of the abdominal aorta are distinctly felt.

One of the earliest symptoms of tubercular meningitis, and one that often aids in the diagnosis when we are in grave doubt, is an abnormal appearance of the eyes; whether it be an inequality in the size of the pupils or very sluggish contraction or expansion with photophobia, this occurrence should put one on his guard against a case which may seem otherwise of little moment. One cannot be too careful in dealing with children, especially with infants, who naturally fear a physician and resent his examination, or he will often be led into expressing an opinion which will have to be retracted later with much confusion; and it is by watching the tell-tale iris that mistakes may often be avoided. On the muscular paralyses producing squint, it is not necessary to dwell, for these appear so late in the disease that a diagnosis should already have been made, or else they follow convulsions, which are clearer indices of brain trouble. When coma has set in, the eyes become set, and the pupils dilated, and toward the end the sight is lost. Nystagmus is often present in the later stages, and some writers describe one eyeball fixed while the other moves.

Convulsions may appear at any period of the attack, sometimes at the very beginning, and are to be regarded as a bad sign; the movements may vary in amount from slight twitchings to general and continued spasms; they vary also greatly in the time that they persist, but after each seizure the child is evidently worse, and usually grows more comatose with each recurrence. When paralysis of any member occurs it is usually during a convulsion.

Stiffness of the neck muscles and retraction of the head is a frequent symptom of tubercular meningitis in common with many other nervous diseases.

As death approaches all the grave symptoms become more pronounced. The pulse becomes very rapid and thready, often reaching 200; the respiration becomes irregular and shallow; the coma is profound and unbroken; the sphincters relax; and the child dies exhausted or in a convulsion. Episthotonos may occur and all varieties of muscular twitchings have been met with. Death is painless;

even in the last three or four days before the end all sense of pain seems lost and what functions of life are performed seem more the result of reflexes than of any guiding power of the will.

This description embraces the prominent features of both varieties; let us now consider how they differ.

Simple differs from tubercular meningitis in various ways that may be recognized clinically, in well marked cases of each. Lewis Smith says, "Differential diagnosis is often difficult, and sometimes impossible." The method of invasion is usually different, for while the latter comes on very gradually, as has been described, the attack of the former is much more rapid, and gives evidence from the very beginning of the presence of grave trouble. Tthe child in a typical case is very sick from the start, with high fever, quick pulse and accelerated respiratory movements, so that there is none of that watching and waiting for something definite upon which to hang a diagnosis so frequently found in tubercular meningitis. The constipation of the simple disease is not nearly so obstinate, and frequently is absent altogether.

The boat-shaped belly is not met with. The vomiting comes on earlier, as do also the convulsions. The whole course of the disease is more rapid and sthenic, if I may use an old-fashioned word. Again, the family history of the patient will afford a clue to the differential diagnosis, although I recall one case of unmistakable tubercular meningitis in a bright little girl of nine years, whose parents are alive and healthy now, 12 years after her death, and whose brothers and sisters, all grown, are healthy men and women, and have healthy children of their own. But even the worst family history must not discourage us, for cases are on record of children who have died of meningitis presenting every symptom usually credited to the tubercular form, and whose parentage made it most likely that it was caused by an inherited taint, but careful investigation after death failed to disclose any tuberculous lesions whatever. So that, while the types of the two varieties of meningitis may be recognized clinically, a positive diagnosis is excessively difficult in many cases, and often will prove false, even when all symptoms seem to point clearly one way. One of the most careful clinical observers that I know said of meningitis, that it is a disease about which he was never positive, for he had seen cases that seemed clearly to be tubercular recover even after consciousness had been lost. I recall a case now, in my father's practice, of a young girl, about ten years of age, whose family history was bad on both sides, who had every symptom of tubercular meningitis, who had many convulsions, was totally blind, and who was unconscious for nearly three weeks, whose case was considered hopeless, and death longed for by the attendants as a relief. Yet she recovered, and is now a healthy, well-developed young woman, every way well and strong. So that I must conclude as I began this paragraph, with again impressing the difficulty of differential diagnosis between simple and tubercular meningitis; it can be made for certain only after death and even then requires often the keenest insight of an expert pathologist.

Prognosis.—The prognosis of tubercular meningitis is bad, a recovery being so rare that the physician is never justified in holding out false hopes to the sorrowing parents; and even those unusual cases that have managed to live through an attack have been so blighted by it that they have remained wrecks of themselves, a mere semblance of human beings. Simple meningitis is more amenable to treatment, so that a hopeful prognosis may be given if the case is seen in its inception, to be modified later on if the course of the disease make it advisable. Let me quote a few authorities; Watson, who classed both diseases together,

wrote: "The prognosis, always doubtful or bad, is a little better when the disease is violent, and occurs in tolerably healthy subjects, than when it creeps on slowly and insidiously, and in weakly, scrofulous patients." So that while the pathologists of that day had not recognized the great difference that we now insist upon, the careful observation of the physician had taught him to divide his hopeless from his hopeful cases, just along the line that we now follow in our more accurate classification. He quotes statistics from continental authorities, which give a death rate in seventy-six cases of seventy-five per cent., and closes his remarks on prognosis in these words: "The cases in which recovery took place were mostly those in which antiphlogistic measures were adopted early." Dr. West, who recognized the tubercular nature of the disease, wrote: "Unfortunately the prognosis in hydrocephalus is so unfavorable that we can scarcely speak of the circumstances which regulate it, for under almost every variety of condition, of symptoms, and of treatment, the patients die. . . . Once I saw recovery take place after the second stage of hydrocephalus had commenced, and once I watched with surprise the gradual subsidence of the disease, though convulsions had already taken place, and had been followed by coma." This case is related in full, and is a remarkable one, as the child was paralyzed, blind and speechless, of a tubercular family, and remained delicate and sickly when seen last, three years after the subsidence of the attack.

West quotes Guersant, of Paris, who said: "Tubercular meningitis may sometimes terminate by recovery in the first stage, though the nature of such cases is always more or less doubtful; in the second stage I have not seen one child recover out of a hundred, and even those who seem to have recovered have sunk afterwards either under a return of the disease in its acute form, or have died of phthisis. As to patients in whom the disease has reached the third stage, I have never seen them improve even for a moment." He refers also to the recovery of a patient of Rilliet, whose record of the case is very complete, that reached the third state; and upon whom a post-mortem, five years afterwards, showed unmistakable evidence of the nature of the former illness. These cases are still curiosities of medical literature.

Rosenthal says: "The prognosis of the tubercular meningitis is very grave. In some cases, in which the exudation is not abundant, it may be absorbed, and the miliary granulations of the meninges may disappear, as has been seen in tuberculosis of other organs. But this favorable termination forms a very rare exception, and does not diminish the gravity of the prognosis." And he refers to a case of Politzer, in which recovery was verified by post-mortem examination after three years, the child having died of a recurrence of the same disease.

Lewis Smith says, "Meningitis is one of the most fatal maladies of early life. Whether the form is simple or tubercular, if the initial stage has passed without proper treatment, death may be considered inevitable. Tubercular meningitis, however early recognized, is rarely amenable to treatment. The prognosis in simple meningitis is not so unfavorable, provided treatment is commenced at a sufficiently early period."

Dr. Samuel Jones Gee, in Reynold's System of Medicine, says, "Tubercular meningitis, running the course which I have now described, has but one termination, and that is death. But it has been suspected, and with good reason, that recovery sometimes takes place in the earliest stage of the disease. The probability of this opinion has been greatly increased by the result of ophthalmoscopic examinations. . . In these cases, however, a recurrence of the disease is to be greatly dreaded."

Dr. J. Spencer Ramskill, in the same System, writes of simple meningitis thus: "The termination of the disease is generally in death; very few cases recover, and only when active treatment has been employed at the very onset.

A. Jacobi says: "The prognosis of tubercular meningitis is a very bad one. It is true that recoveries have been reported;" and he refers to several that have been verified subsequently at autopsies. Of his own large experience he says: "I have seen what I thought to be a recovery; it was followed by death from necrosis of the cranial bones and secondary meningitis superinduced by the tartar emetic torture. Another case of mine was that of a boy of two years. When growing up he was stupid, eccentric, wilful and lazy. He is now nearly thirty years old, and lives in an insane asylum. A third case, in which the diagnosis of tubercular meningitis was possibly correct, terminated in incurable blindness. These are the best results I can boast of. Thus, when the diagnosis is beyond doubt, the prognosis may be considered absolutely bad."

From these quotations we may readily conclude that any case of tubercular meningitis that has advanced far enough to be recognized is practically hopeless. It is utterly useless, from a clinical standpoint, to discuss the question of a possible spontaneous recovery from the initial stage of the disease: the main point is that we have to deal with a case sure to be fatal and permitting only abortive attempts to relieve symptoms.

Osler doubts the accuracy of the pathology of those who have reported cases of recovery on the strength of subsequent post-mortem examinations.

The prognosis of simple meningitis need not be nearly as grave, especially if we have the good fortune to recognize the character of the malady at an early date. This is a disease that needs, more than any other, early, active treatment and unremitting attention throughout, and it is only by giving this that a favorable prognosis becomes possible. Precious time lost in the beginning can never be recovered. But with an early diagnosis, correct treatment and careful nursing, a fair proportion of cases can be pulled through.

Treatment.—Any treatment of tubercular meningitis to be of use must be instituted at an early date, for all authors agree that once the products of inflammation have progressed beyond a certain indefinite point, which varies in every case with the resisting power of the child, but is reached in every case very soon after the disease gains headway, all treatment is then useless. It is well also to bear in mind this paradox, that this is a disease best treated before it begins, so that when we have in charge delicate infants of tuberculous parents we must constantly be on the lookout for meningitis, and guard against its occurrence. The child should be well nourished, kept warm and dry, live in bright rooms and breathe always a pure atmosphere; it should go to bed early and be allowed to have plenty of rest during the day, with exercise out of doors in fair amount whenever the weather permits; it should not be overstimulated physically or mentally, a certain awkwardness or backwardness of intellect being far preferable to that infantile precocity of the present day which, above everything else, is apt to lead to intra-cranial trouble. The child should be carefully nursed and guarded against falls or blows on the head; it should never wear tight clothing which might constrict the neck, nor be placed in positions on the nurse's lap which could produce undue pressure on the brain. The bowels should be watched and constipation avoided always. Good milk from a healthy source, whether the mother's or cow's milk, should form part of its food long after the time when children usually are weaned, and after any little illness cod liver oil with some form of iron, the syrup of the iodide being excellent, should always be given dur-

ing convalescence. If in spite of the most watchful care it develops symptoms that lead us to suspect meningitis, what should we do? In answer, let me quote again.

Watson advises leeching, from three to six leeches being applied to the temples or mastoid, of children from six months upward, remembering always that each individual case is to be treated for itself and the rules modified to suit it. They should be applied as soon as we make the diagnosis, and enough blood should be taken to affect the disease. At the same time brisk purgation should be induced, and his first choice is calomel in his prescriptions to produce this effect; and to show how obstinate the constipation is, he relates cases of remarkable tolerance of this drug. Cold should also be applied to the head; on this point he is satisfied with cold water bandages, and discourages the use of the ice cap. This is about all of his treatment, of which he speaks with very little hope, giving much more attention to the prevention of the disease. He concludes, "I do not feel called upon to say anything in addition to what I stated in a former lecture about other remedies that have been proposed in acute hydrocephalus—digitalis, colchicum, squills, antimony. These may be useful when they act as diuretics; but they have no specific virtue. I have told you the remedies which I believe to be the best, and which will save the patient, when judiciously used, if the case be within the compass of our cure, and you will do well to learn how to use these powerful means. I am confident you will find that more to your purpose than trying now this, now the other remedy, because it is new, or because some persons tell you they have had wonderful success with it."

Dr. Francis Condie, who revised Watson's lectures in 1845, calls attention to the use of the iodides in this disease, and quotes cases in which benefit followed their exhibition.

Dr. Charles West relies upon the same remedies, giving free purgation with calomel or any efficient drug, at the very beginning, and keeping the bowels relaxed for several days; he recommends leeches also, but applies them to the vertex, and insists upon the constant application of cold to the head. He discusses the iodides and uses them, as the course of treatment most encouraging in his hands. His approval is not enthusiastic. The diet should be watched, and violence of delirium and restless wakefulness should be controlled by opiates.

Rosenthal's treatment of tubercular meningitis is prophylactic. After the disease has begun, he says that treatment is purely symptomatic. He refers to the measures enumerated by the older writers, but recommends none, apparently considering the case hopeless. For the simple form, he recommends rest, cold to the head, in the form of compresses, purgatives and light blisters. He considers mercurials useless. He speaks well of narcotics in severe forms with excitement.

Dr. Gee speaks of tubercular meningitis in the usual hopeless way after it has passed the stage of invasion. He uses cold to the head, keeps the child quiet, relieves constipation, gives bromide of potassium for convulsions, and hopes against hope.

Dr. Ramskill says of simple meningitis, "The treatment of acute meningitis is only successful when employed very early in the disease, and carried out with energy. It resolves itself into three great remedial measures; first, blood-letting; second, hard purging; third, application of cold water or ice to the head." For children he prefers leeches to venesection, and mentions carotid compression as an alternate measure in place of repeated leeching. Of the purgatives he prefers croton oil, because of its prompt action in small doses. He ascribes a certain

specific action to mercury, in addition to its purgative effect. The cold may be applied by the ice-cap, or better by direct irrigation with a stream of cold water. This is so effectual and powerful in its action that it must be carefully watched; warm applications to the extremities increase its efficiency. He advocates the use of blisters in the later stages, and Dr. Harry Hartshorne, who edits his work, adds his voice to the beneficial effect of blisters, although he recognizes that many modern authors deny that they do any good. If the case be complicated by rheumatism, that should receive appropriate alkaline treatment.

Dr. A. Jacobi warns us to guard against the occurrence of tubercular meningitis, and outlines the usual treatment of watchfulness, cod liver oil, arsenic and iron. He says further, "When tubercular meningitis is diagnosticated during the prodromal stage—a rare occurrence—noise and light must be excluded, and absolute rest enforced. Even at this early period the prognosis is bad. Altogether, no treatment can be entered upon with any degree of probability of saving the patient. There are indications for treatment, and in the present condition of therapeutics we can do no better than to fulfil them with conscientiousness and —hopelessness." He goes over the usual list of remedies without commending any. Iodide of potassium is the only agent that produced any effect in his hands, and that only to prevent effusion, when hundreds of tubercles were found post-mortem, a child of two years having taken from one to three drachms daily. For vomiting he gives pills of ice and opiates; if it persists the food is given by enemata; cardiac stimulants are required for weak heart; convulsions indicate chloroform, chloral or the bromides. Ice on the head of infants is apt to produce heart failure. Antipyrin or phenacetin will keep down the temperature.

Dr. Lewis Smith lays down the rules of prophylaxis very clearly, as I have indicated them; he discourages bleeding, except in very robust children; he sees no good in mercury, except as a laxative, and warns us against its effect on the mouth and as a general depressant; he favors ice to the head; but relies upon bromides and iodides as the only remedies worthy of serious consideration in fighting the progress of the disease, and these should be begun early and used continuously; if with these the patient does not improve there is no remedy.

Osler, in his Practice, just out, says of tubercular meningitis: "The prognosis in this form of meningitis is always most serious. I have neither seen a case which I regarded as tuberculous recover, nor have I seen post-mortem evidence of past disease of this nature. Cases of recovery have been reported by reliable authorities, but they are extremely rare, and there is always a reasonable doubt as to the correctness of the diagnosis."

Of simple meningitis he says: "There are no remedies which in any way control the course of acute meningitis;" he then mentions very briefly all the remedies that have been advised by different authors already quoted, and concludes: "The application of an ice-cap, attention to the bowels and stomach, and keeping the the fever at a moderate height by sponging, are the necessary measures in a disease recognized as almost invariably fatal, and in which the cases of recovery are extremely doubtful."

This view, I feel sure, is altogether too gloomy; the disease is not so recognized by any of the authorities that I have quoted; in fact, all hold out good hopes in cases properly treated. Everything depends upon the early diagnosis; the differential diagnosis between simple and tubercular is not so essential, for the treatment in each case should be the same, but we must recognize that meningitis is present and not one of the many infantile complaints that simulate it. Even with children whose parents are evidently tubercular, we must not too hastily

conclude that the case is tubercular and therefore hopeless, for there are records of post-mortems held upon such cases, which revealed no tubercles whatever. In any case, then we may safely follow what all teach: that absolute quiet be observed, best in a darkened room far removed from the noises of the street; that constipation be at once relieved by free purgation, and that this be continued as long as necessary; that a moderate amount of blood be abstracted from children able to stand it, preferably by leeches applied to the head; and to others advising this, I am able to add the authority of Dr. Wm. T. Howard; that the head should be kept constantly cold by external applications, of which the ice-cap or cold coil are the best: that fever be controlled by sponging or the use of antipyretics; that counter-irritation is of doubtful utility; but if used the thermo-cautery should be the means; that rest must be obtained by the use of opiates or other hypnotics if necessary; that the best, and indeed the only medicines worthy of mention are the iodides and bromides in full doses administered continuously.

CONCLUSIONS.

1. Meningitis is a disease of frequent occurrence in children; its onset is often insidious. It is therefore to be guarded against, and carefully treated from its commencement.

2. It is most amenable to treatment in its incipiency; after passing the first stage cases of simple meningitis recover infrequently, and then only after most careful nursing and treatment; tubercular meningitis, once well established, yields to no treatment, the reported cases of recovery being so infinitesimally few that they may be disregarded.

3. The best treatment up to date consists of absolute quiet, moderate blood-letting by leeches, free purgation, the constant application of the ice cap, or other cold to the head, and the bromides and iodides internally with good, light nourishment.

THE SYMPTOMS AND TREATMENT OF NEURASTHENIA.

BY G. H. GREELY, M. D.,

Assistant in the Medical Department of the Johns Hopkins Hospital Dispensary.

The symptoms of this disease are so extremely variable as not to admit of anything like accurate classification, though many able and extensive articles have been written for that purpose. There are, however, some symptoms that are generally present in all forms of neurasthenia, and their recognition will aid materially in the diagnosis.

With the exception of the menopause form the disease is rarely met with outside of early adult life. It is somewhat more common in females than in males. It is most frequently seen in those of a neuropathic tendency. Emotional disturbances of any character predispose to it; thus: excessive mental labor, late hours, insomnia, sexual excesses, masturbation, improper or insufficient food, inordinate use of tobacco. The prolonged action of these causes in the young produces irritability of the medullary and vaso-motor centers, and thus the vascular equilibrium of the cord is lost.

These patients are not necessarily (as have often been stated) weak and anæmic. On the contrary, they often possess an unusual degree of strength and vigor. One that I saw recently was a modern Sampson. They are generally more or less despondent. There is a heavy, dull, listless expression. Perhaps the

most common and constant symptom is the cold, congested hands, sometimes almost cyanosed. The tongue is usually coated: constipation is the rule. Dyspepsia, flatulence and anorexia are frequently present.

Their emotions are easily excited. Thus, upon s suring a lady recently that she was not seriously ill, who fancied she was the subject of cardiac disease, to my surprise she burst into tears. The reflexes may be normal, although they will generally be found to be slightly exaggerated. The pupils are, as a rule, equal, though the reverse may be seen in a small percentage of cases. An uncommon condition is limitation of the field of vision. The pulse is an interesting feature of the disease. It is almost invariably above normal, sometimes during examination going up to 150, and so forcible is the throbbing that it is suggestive of aortic insufficiency.

Pulsation in the arteries is almost always seen, and exceptionally seen in the veins. The manner in which the patients describe their feelings is somewhat characteristic. They invariably complain of shooting pains, not in one, but in several places. Thus, an aching pain in the back, stabbing pain in side, and feeling of oppression in the stomach. They commonly give a history of having had these symptoms several years. Patients not infrequently complain of what they term "pressure on the stomach." With this is generally associated a feeling of malaise, headache and dizziness; occasionally this terminates in actual vomiting. This is, however, more apt to occur with women. Absence of premonitory nausea aids in differentiating from vomiting due to other causes. Peristaltic unrest, a condition in which the peristaltic movements of the stomach are so increased that borborygmus may be heard even at a considerable distance, is sometimes met with. This may go on even to distressing abdominal cramps, necessitating the use of morphine for their relief. I saw such a case last summer in a young lady; they occurred several times daily, rendering her existence miserable.

There is a mild form of melancholia to be observed in all neurasthenics.

They invariably imagine themselves the subject of some serious disease, and frequently develop such a morbid condition of mind, as to prepare themselves for sudden death, make their wills, give up business, etc.

The treatment is almost wholly moral. The first measure is to secure complete rest of mind: out-door life, regular habits, nutritious diet, restful sleep, change of scene. The Turkish bath has in some cases proved useful. Bicycle riding and sea bathing, when practicable, are highly recommended. Alcohol in any form should be positively interdicted. Strychnia in the form of the tincture of nux vomica is perhaps the most useful agent we have, though iron, and the various forms of hypophosphites, should be used if anæmia be present.

Assuring the patient that his condition is not serious, encouraging him to turn his thoughts towards anything but himself, and promising ultimate recovery, are possibly the most important features in the treatment.

"It was heart failure," say the doctors, and they say it so often that we put on our thinking caps. One business man after another falls out of sight, and when we ask what the trouble was the reply is sure to be "heart failure!" A great deal of worry, a habit of constant hurry, keeping at high tension year after year—that's what's the matter. We sleep with one eye open, talk business in our dreams, swallow a whole meal—soup, entrees, roast and dessert—with one gulp, and then when we hover about the fifties, the heart gets disgusted at its treatment and closes up the concern.—*Ex.*

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BALTIMORE, JUNE 25, 1892.

Editorial.

VENOMOUS SNAKES OF THE UNITED STATES.

In the *Trans. Southern Surg. and Gynecolog. Association*, 1891, Dr. Barringer, of the University of Virginia, presents an interesting article upon this subject. Among the many privileges which this great country enjoys is that it is comparatively free from poisonous snakes.

Nine-tenths of our snakes are destitute of fangs and poison-bags. Their bite is dangerous only in proportion to the toxic effects of the whiskey given to the patient by alarmed friends.

Among the poisonous snakes, the rattlesnake, the copperhead and the water-moccasin have established a reputation for deadliness of venom which is unquestioned. The first of these three is sluggish, the second extremely agile, the third malicious.

The venomous qualities of the *elaps fulvius* are, on the contrary, not generally recognized. This beautiful little snake, commonly known as the harlequin snake, bead snake, or coral snake, is the sole American representative of the *cobra* family, and is found from Virginia to Texas. It is from 16 to 20 inches long, of a blue-black color, with brick-red and yellow bands, and its tail barred with yellow. It is gentle and will often bear handling without biting. Weir Mitchell has stated that it is not poisonous, but it has fangs, and Dr. Barringer reports a case where a man died in 18 hours from its bite.

Our poisonous snakes, apart from the *elaps*, have pits between the eye and nostril, and one or more of the ventral plates behind the anus undivided. As secondary marks we may note the elliptical vertical pupil, the triangular head, narrow neck and blunt tail.

Healthy snake venom contains no bacteria.

Dr. Barringer finds death in less than 10 per cent. of rattlesnake, and 1 per

cent. of copperhead bites. He has not learned of any deaths from the moccasin snake-bite.

The best protector against snakes is the hog. The bear, being the foe of the hog, is the patron of the snake.

In case of snake-bite, apply a tourniquet, cut or tear open the wounds till they bleed, and suck or cup them. Inject a 10 per cent. solution of potassium permanganate or a strong solution of liquor potassæ into the wound. Give whiskey freely, and keep the nervous centres working with hypodermics of $\frac{1}{30}$ to $\frac{1}{20}$ grain of strychnia. Loosen tourniquet periodically to prevent gangrene. Such loosenings admit the venom little by little into the system, and this must be met again by alcohol and strychnia.

After 5 per cent. of snake-bites chronic septicæmia with nerve disorders occurs, because of the presence of septic bacteria in the saliva of the snake left from its food. These germs flourish in the mouth mucus of the snake, which is so abundant in the copperhead as to give it the popular name of the "cotton-mouth" snake.

The moral of it all is: Spend your vacations in districts, such as the Adirondacks, which are too far north for snakes; or else wear protective leggings.

A CO-OPERATIVE SUMMER RESORT.

High up on the Blue Ridge Mountains, in Western Maryland, and close by the railroad, is a summer resort which is the embodiment of the spirit of co-operation—co-operation between different classes in the social world, and at the same time co-operation between those of the same class.

Here a self-supporting young woman, who lacks either the means or the opportunity to take a summer trip to the popular resorts, can join with others circumstanced like herself in a vacation of two weeks at cost price, in a healthful mountain region, with excellent table, cheerful companionship, and opportunity for rest and quiet.

The cottage itself, which bears the name of Vacation Lodge, in its furnishings is a surprising revelation of the beautiful and cozy effects which a cultivated talent for decoration can produce with the cheapest and most ordinary materials. It affords ample accommodation for thirty guests.

We call the attention of our readers to the subject, because we all from time to time have patients who might, by a few week's vacation, be saved from prolonged sickness; yet who, although they could pay a moderate sum for the trip, have no place where they can go alone and find pleasant companions.

The city office of the "Lodge" is in the Wilson building, N. E. corner Charles and Saratoga Streets, room No. 24; and the office hours are Monday and Thursday, from 12 to 3, and Saturday, from 5 to 8.

HEAT-STROKE IN CHILDREN.

There must be, in our great cities, numerous cases of heat-stroke in infants and young children; yet our text-books and journals say little or nothing about them.

We should expect to find them among those cases of sudden indigestion in hot weather, which yield quickly to cold applications to the head and body; the indigestion appearing to be rather a minor symptom.

Especially in such hot weather as that brought in by June, when it seemed as if the tissues of the whole body cried out for moisture, would we be likely to meet with cases.

Which of our readers will give us some experiences upon this point for publication?

Reviews, Books and Pamphlets.

A Text-book of the Practice of Medicine for the Use of Students and Practitioners By R. C. M. Page, M. D., Professor of General Medicine and Diseases of the Chest in the New York Polyclinic; author of "A Chart of Physical Signs of Diseases of the Chest," "A Hand-book of Physical Diagnosis of Diseases of the Organs of Respiration and Heart." Octavo, 578 pages, illustrated. Red parchment muslin. Price, $4.00.

The careful work presented by this author in his well-known book on the diagnosis of the diseases of the chest will incline the medical public to a favorable reception of this more extensive effort. The value of the work is increased by the insertion in many places of the personal experience of the author, and of the prescriptions which he has found most serviceable in the relief of each ailment.

The International Medical Annual, and Practitioner's Index for 1892. Edited by P. W. Williams, M. D., Secretary of Staff, assisted by a corps of thirty-two collaborators—European and American—specialists in their several departments. 644 octavo pages. Illustrated, $2.75. E. B. Treat, Publisher, 5 Cooper Union, New York.

The tenth yearly issue of this valuable one-volume reference work is at hand. The corps of department editors is representative in every respect. A number of illustrations—many of which are in colors—make the "Annual" more than ever welcome to the profession. Part I comprises the New Remedies, together with an extended review of the Therapeutic Progress of the year. Part II, comprising the major portion of the book, is given to the consideration of New Treatment; and is a retrospect of the year's work, with numerous original articles by eminent authorities. The third—and last part—is made up of miscellaneous articles, such as Recent advances in Bacteriology; Medical Photography; Sanitary Science; Use of Suppositories in the Treatment of Disease; Improvements in Pharmacy; New Inventions in Instruments and Appliances; Books of the Year, etc.

The arrangement of the work is alphabetical, and an elaborate index is added.

The work has the advantage of compactness; and a treatise of one volume is always handier than one of two or more volumes. We find the first article of the book discussing the philosophic principles on which the new synthetic drugs are being developed especially interesting.

The Harvard Medical School Association has issued an interesting and valuable list of its members, which it will be glad to send to gradnates of the Medical Department of the Harvard University, in whatever part of the world

they may be. The Association was formed about one year ago, and all graduates of the School are eligible to membership. The object is to unite all alumni and to advance the interests of the school and of medicine. The entrance fee and the annual assessment are merely nominal.

Medical Progress.

CAUSATION OF TYPHOID FEVER.

In a discussion before the Association of American Physicians, Dr. V. C. Vaughan, the well-known bacteriologist of Michigan, said (*Boston Med. and Surg. Jour.*): Certainly the great epidemics of typhoid in the cities generally start from the pollution of the drinking water with typhoid stools, but I also believe that typhoid fever may originate without a pre-existing case of typhoid fever. I have seen cases of typhoid fever scattered amongst the farming population, amongst men, women and children who have not been off of their farms for weeks, and it would take a good deal to convince me that there was a common source of infection in these cases. I believe there are different germs, or different varieties of the same germ, that may cause typhoid fever, and that they are widely distributed.

UNJUST HEALTH LAWS IN CHICAGO.

The members of the Chicago Medical Society have had a taste of the unfair laws which Health Boards will cause to be enacted if not watched and resisted by the medical profession. A committee of that Society reports (*Chicago Med. Recorder*, June, 1892) that "dissatisfaction has legitimately arisen, and a circular letter, issued from the Health Office last autumn, is in itself justification for some indignation. Its tone, wording and directions are calculated to provoke resentment in any body of intelligent men, and must be deprecated under existing circumstances, where the public health depends in no small degree on the harmonious and mutual support of this important municipal office by the medical profession. In it we find that a suggestion of the State Board of Health recommending the placarding of premises for thirty days, in a case of any contagious disease, is made an invariable order. We have to respectfully urge that, in many slight cases of diphtheria and scarlet-fever, such a length of time is needless and works great hardship. We can see no propriety in maintaining a placard ten or twenty days after the disease has disappeared, the place having been fumigated, and every reasonable precaution complied with, thereby enforcing a quarantine, depriving children of their schooling, and often ruining people in a small retail business, or the keepers of boarding houses. We submit that the attending physician is the best judge of the proper time for removing the placard, and upon his recommendation, and an inspection by the Health Office, this should come down at the earliest reasonable moment.

"Further, we are unable to find any authority for placing upon the physician the arduous police duty of seeing, in the case of death from a contagious disease, that the body is placed in an air-tight coffin, which is to remain in the sick-room until removed for burial, and that all articles worn by, or that have come in contact with the patient, together with the room and all its contents, should be thoroughly disinfected by burning sulphur. This is a labor that cannot be thrust upon the attending physician by the ipse dixit of any office-holder, and it is doubtful if any law imposing this obligation, without compensation, would be constitutional. It seems to your committee that this duty inheres in the Health

Office, and can neither be delegated by them to the physician nor shirked off upon a profession that already is unjustly imposed upon by an exacting public.

"In this connection we desire to enter a protest against being forced, without compensation, to report cases of contagious disease to the Health Office.

"It also comes to our notice that the visit of the medical inspectors of the Health Office have, in numerous instances, been conducted with such lack of consideration for the attending physician that he has been needlessly embroiled with the family, to his professional and pecuniary detriment, when his only effort seems to have been the discharge of his duty under an exacting law. For this there appears no sufficient excuse.

"As a result of the unfortunate unpleasantness that has arisen, we are informed that many cases of mild scarlet-fever are denominated rose-rash, and of mild diphtheria are called pharyngitis, to avoid the difficulties and inflictions of the present Health Office regulations. Much as this practice is to be deprecated, it is probable that under existing circumstances it will continue to increase."

The report was adopted by the Society and a committee appointed to adjust matters.

OXYGEN INHALATIONS.

In an interesting contribution to the *Chicago Medical Recorder*, Dr. N. S. Davis, Jr., remarks:

Briefly it can be said that the indication for oxygen inhalations in respiratory affections is cyanosis. It can be expected to give prompt and very great relief in acute dyspnœa with cyanosis; such as often accompanies asthma, acute capillary bronchitis, broncho pneumonia, croupous pneumonia, œdema of the lungs, or pneumo-thorax. Usually œdema of the lungs develops at a time when permanent relief is impossible, as the patient is already too much enfeebled to combat the primary malady, but the best results can be expected when œdema threatens or develops early, while the heart and respiratory muscles are still fairly vigorous. Good results can be hoped for in a self-limited disease of short duration such as croupous pneumonia, for by oxygen sometimes life can be maintained until the crisis in the malady is past. Unfortunately, as the reports of its employment in pneumonia show, when cyanosis and œdema develop, the case rarely terminates by crisis, but is prolonged. As digitalis finally fails to stimulate a flagging heart that is extensively degenerated, so in pneumonia, oxygen, though signally efficient at first, finally fails to maintain a good degree of oxygenation of the blood.

A degree of greater well-being can be expected even in chronic dyspnœa, but it will be less marked than in acute.

EFFECT OF PNEUMONIA ON THE KIDNEYS.

In closing an article upon this subject (*Chicago Medical Recorder*, June, 1892), Dr. I. N. Danforth sums up his conclusions as follows:

First. Pneumonia may, and generally does, produce some degree of hyperæmia of the kidney; the amount of hyperæmia depending partly upon the area of lung involved and partly upon the temperature of the patient.

Second. Albuminuria is frequently present in pneumonia, beginning in the early stage, and continuing until defervescence is established, when it generally disappears.

Third. Hyaline tube casts are not uncommon in pneumonia, but they are likely to be small, few in number, and destitute of morphological elements, and are therefore likely to escape notice.

Fourth. The albuminuria of pneumonia may persist, and become the starting-point of chronic nephritis.

Fifth. In many cases, chronic interstitial nephritis antedates the pneumonia attack.

Sixth. Experience shows that renal congestion, as demonstrated by albuminuria and tube casts, may occur in any and every case of pneumonia; therefore the usual methods of diagnosis of renal lesions should be employed in every case of pneumonic invasion.

Seventh. There are no characteristic or constant ulterior effects produced by pneumonia upon the kidneys; but if any such effects follow, the most likely lesion is chronic parenchymatous or tubal nephritis.

THE BEST NUTRITIVE ENEMA.

Ewald, as a result of experiments, found that eggs, even though not peptonized, were to a considerable extent absorbed by the rectal mucous membrane. According to the *Mercredi Medical* for April 1st, Huber, of Zurich, has recently repeated Ewald's experiments in Prof. Eichhorst's clinic, and announces that the absorption of raw eggs is greatly aided by the addition of common salt. The salt is well borne, and causes, as a rule, no irritation of the bowel. He considers that eggs beaten up with salt, in the proportion of fifteen grains to each egg, are the best for nutritive enema. His method of procedure is as follows: Two or three eggs are taken, and thirty to forty-five grains of salt are added. They are slowly injected by means of a soft rubber tube, carried as high up the bowels as possible. Three such enemata are given daily. An hour before each enema the rectum is cleaned out by means of a large injection of warm water.—*N. Y. Med. Times.*

ARREST AND TRIAL OF A TRAVELING MEDICINE MAN.

Considerable interest was excited by the case of the State of Maryland vs. Charles McKay, alias Oregon Charley, which took up the better part of Friday, June 17th, in its trial before Justice Bitner.

The traverser in the case has for some time past had a tent pitched in the neighborhood of Locust and Bethel Streets, in this city, where he has been consulted by many persons for relief from various bodily troubles and ailments, has given them advice, furnished medicine, etc. He appeared to be doing well and to be giving general satisfaction to those that consulted with him and followed his advice.

Friday he was brought before the Justice charged with practicing medicine in violation of the laws of the State.

The law under which he was accused and tried was passed at the last session of the Maryland Legislature and has not yet been published in book form, the only evidence of the law being a written copy certified to by the Clerk of the Court of Appeals.

That law provides, under penalties ranging from fifty to two hundred dollars, that no one who is not now a practitioner of medicine shall be allowed to practice in this State, without possessing a diploma from some regular medical college, on obtaining a license to do so, either from the State Board of Regular physicians or the Board of Homœopathic physicians, which are the only two medical schools that are recognized under the new law.

Athough the traverser had no such license to practice in Maryland, and produced no diploma from a medical college, yet there was no evidence to show that the traverser had not practiced medicine outside the State of Maryland, and as the

law was entirely prospective in its operation and referred to those who were not practitioners at the time of its passage, the magistrate rendered a judgment of "not guilty."

If the party came to this State after the passage of the Act under which he had been arrested, yet even then, if he had been a practitioner of medicine in another State, the Constitution of the United States would protect him in the exercise of his profession here, as that instrument clearly prohibits any State from passing a law interfering with the rights and privileges of a citizen of any other State. It was incumbent upon the State to show that the traverser had not been a practitioner in the State from which he came, and this they had totally failed to do.—*Hagerstown Daily News.*

TREATMENT OF ANTE-PARTUM HÆMORRHAGE.

The *Lancet's* Paris correspondent contributes the following description:

The management of flooding due to malposition of the placenta—a condition erroneously designated by Rigby as "unavoidable hæmorrhage"—is a matter which has put to the proof the ingenuity of generations of accoucheurs. At this faculty reliance has hitherto been placed upon plugging of the vagina, and I much doubt if Barnes' views as to the efficacy of detaching the placenta from the "dangerous zone" have ever been frankly accepted here. The introduction into practice of Barnes' bags marked a distinct progress in this branch of obstetrics; but the results obtainable therefrom were not so good that practical men were debarred from seeking still more efficient and expeditious means of averting the dangers run by the subjects of this condition—not to mention their progeny. Your readers will be glad to have laid before them Professor Pinard's new treatment of this dangerous complication of pregnancy. The slight hæmorrhage generally marking the commencement of the trouble is treated in the ordinary way by absolute rest in the horizontal position—the head low and the pelvis raised. Vaginal injections are made with a 1 in 2000 solution of red iodide of mercury, a 1 per cent. carbolic solution, a boric acid solution, or simply water, all at a temperature of 118·4° F. This vaginal *lavage* should be continued until the returning fluid is colorless. Opiates may be advantageously administered, and should the presentation be a cross one, turning by external manipulation may be practiced.

Should hæmorrhage continue, radical measures must be had recourse to in order to induce labor. All due antiseptic precautions being taken, one or two fingers, or even the entire hand, are introduced as far as the internal os, where the membranes are freely ruptured either with the nail or with a special membrane-perforator.

A Champetier de Ribes intra-uterine bag is now introduced, chloroform being administered in the case of nervous patients. For its introduction, two fingers of the left hand are passed up to the os, which is then drawn slightly forward. Forceps with an antero-posterior curve is now introduced, carrying with it the bag, empty and folded, and which, well anointed with boracic vaseline, is gently pushed through the os towards the side where the placenta has been diagnosed to be present. The forceps is now disjointed and removed, leaving the bag in the uterine cavity, it being maintained in position by the left hand of the operator. The bag is then slowly filled through a tube connected with it with about 400 grammes of water. The tap is turned off, and for greater precaution a clamp is placed on the tube outside the vulva. The distended bag, compressing as it does the detached placenta, arrests infallibly all further chance of hæmorrhage at the same time that it excites uterine contractions—the precursor of labor—after a

brief delay, this delay being longer or shorter according to the degree of distension of the bag. A recurrence of the hæmorrhage being possible after the expulsion of the after-birth, the patient must be watched, such a complication being combated with intra-uterine injections at 118·4° F., no ergot being given. In serious cases champagne should be administered, together with subcutaneous injections of ether, and the lower limbs should be thickly enveloped in cotton-wool.

And now for the statistics of the application of this apparently highly practical method. Six out of seven cases recovered without an accident, the seventh dying of septicæmia, due to the presence of a degenerated uterine tumor. Of the seven fœtuses, four were born, living and healthy, one was in a macerated condition, and two were stillborn. From the moment of the introduction of the bag until complete dilatation, and the consequent expulsion of the bag into the vagina, in four instances an interval of from two hours and a half to three hours and a quarter elapsed, the intervals in the remaining three cases having been six hours and ten minutes, nine hours and a half, and nineteen hours and a half respectively.

TREATMENT OF PLEURITIC EFFUSION.

Dr. Thorongood writes thus to the *Brit. Med. Jour.*, May 28:

From such experience as I have had with the salicylate of sodium in cases of pleuritic effusion, I believe it to be often of service. It seems to act by reducing temperature and abating fever; and when this result is brought about, especially in cases of recent effusion, absorption proceeds at once. I have often remarked at the bedside that you do not get a pleuritic effusion to absorb while any inflammation or fever is going on.

In Victoria Park Hospital it has not been an uncommon thing for a patient to be admitted with one chest full of fluid, and after several days' rest this effusion has gradually gone away. I remember how my colleague, the late Dr. Sutton, used to enjoy telling me such cases where a pleuritic effusion vanished under treatment with tinct. cardam. co. ℥ss, aquæ puræ ℥j, t. d. s.

Mercury, I believe, limits inflammation in serous membranes, and so promotes absorption. When the absorption commences, the further administration of mercury may often be stopped. For years I have employed mercurials in recent pleurisy, and only once did I salivate a patient. In that case we rubbed mercurial ointment over a blistered surface, and, with some soreness of his gums, the patient recovered quickly.

I have given the tincture of the bryonia alba, a medicine that appears to be a good deal used for rheumatism, being known to all our chief chemists, and I certainly can speak favorably of it as checking inflammatory pleurisy and assisting absorption of fluid. The tincture is usually made according to the form given in the *United States Pharmacopœia*. I am told that the public use the sliced root of the bryonia for rubbing rheumatic joints. Like the salicylate, it is quite one of the antirheumatic medicines.

Before tapping a patient, it is a great advantage to be able to get the temperature down, for then the chance of another collection of fluid is not great. Draw off the fluid rapidly, while temperature is still a febrile one, go on till the patient coughs violently, show the admiring friends a big lot of fluid, and depend upon it very soon you will be again called in to repeat the operation.

PULMONARY ATELECTASIS AS A CAUSE OF ANÆMIA.

At a meeting of the California Medical Society, a paper was read upon this subject (*Pacific Med. Jour.*, May, 1892), by Dr. A. Abrams, of San Francisco, whose

observations, including measurements of the amount of hæmoglobin before and after treatment by forced inspiration or the inhalation of relatively compressed air by means of the pneumatic cabinet (these observations covering twenty-five cases in private practice), had led him to the following conclusions: (1) Physiological atelectasis of the lung is a frequent condition. (2) It may be readily diagnosed by the presence of circumscribed areas of lung dulness, which disappear after repeated forced inspirations. (3) Physiological atelectasis of the lung is frequently associated with anæmia. (4) In all cases of anæmia of obscure origin examination for atelectasis of the lung should be made. (5) Anæmia, due to physiological atelectasis, may be cured after inflation of the lungs. (6) Forced voluntary inspirations are an excellent substitute for inhalations of pure oxygen, and are of great value in anæmia from whatever cause.

CAMPHOID: A NEW SUBSTITUTE FOR COLLODION FOR MEDICAL USE.

It is known that iodoform is soluble (1 in 10) in Rubini's solution of camphor composed of equal parts by weight of camphor and absolute alcohol "[the original has "dilute" alcohol, which is, of course, a mistake.—Ed. *Amer. Drugg.*] "This requires fixing on the part to which it is applied. I therefore added one part of pyroxylin to 40 parts of the solution and found it to dissolve readily.

Applied to the skin, this preparation dries in a few minutes, and forms an elastic, opaque film which does not wash off. The excess of camphor seems to volatilize, and as it disguises the odor of the iodoform, its solution forms a useful vehicle for applying this drug. Pyroxylin dissolves readily in the simple solution of camphor, and this forms a cleanly basis for the application of many medicaments to the skin, such as carbolic acid, salicylic acid, resorcin, iodine, chrysarobin, and ichthyol.

Wm. Martindale, in *Pharm. Jour.*, April 9th, suggests the name "camphoid" for the simple pyroxyline solution.

The formula for *Camphoid* would then be as follows:

Camphor	20 parts.
Absolute alcohol	20 "
Pyroxylin	1 part.

—*American Druggist.*

NEW METHOD OF EXAMINING SPECIMENS OF BLOOD.

A method of making permanent preparations of blood has recently been described by Dr. R. Muir in the *Journal of Anatomy*, which promises to be of great use in clinical investigation. The specimens thus prepared can be preserved indefinitely, and compared with others obtained from the same patient at subsequent periods. The method is quite simple. The films are prepared on coverglasses in the usual way, and, before they have time to dry, are placed in a saturated aqueous solution of corrosive sublimate (to which a little common salt may be added) for half an hour. The corrosive sublimate is then washed away with a three-quarter per cent. solution of common salt, and the film is further hardened by a few minutes immersion in methylated spirit, and then the absolute alcohol. The specimen can then be stained by the ordinary reagents, very good results being given by double staining with eosine and hæmatoxyline, the red corpuscles being stained by the eosine, while the nuclei of the leucocytes are prominently revealed by the hæmatoxyline.—*Lancet.*

CATARRHAL LARYNGITIS OF BICYCLISTS.

Dr. Rayoneau, (*Med., Neuigkeiten*, No. 2, 1892) describes it as follow: Acute beginning; sensation of dryness; cough, with somewhat mucous expectoration

and now and then faint streaks of blood. The voice is changed: the mucous membrane of the throat is reddened. The writer has observed these symptoms in nine young men who rode the bicycle to excess several times a day. The mouth breathing, the rapidity and the pressure with which large quantities of air are forced into the larynx and lungs are the cause. In all cases avoiding of the cause was followed by rapid recovery.—*Cincinnati Lancet-Clinic.*

Medical Items.

A new ophthalmological clinic, which is stated to be one of the best equipped in France or elsewhere, was recently opened in the University of Montpellier.

Small-pox is said to be breaking out in most of the European cities, and cases have lately been reported from New York, Boston, Philadelphia, Chicago, Pittsburgh and the Ohio valley.

Dr. Hammond, of Washington, has collected seventy cases which have occurred in that city during the last ten years, of men dying suddenly from running after street cars.—*Ex.*

Calomel is recommended by Dr. J. B. James, of London, as an excellent topical application for hæmorrhoids. It is said to relieve all pain and uneasiness, and enables the patient to attend to his usual business without inconvenience. —*Medical Fortnightly.*

Nothnagel has pointed out the curious fact that, when a crystal of carbonate of soda is applied to the peritoneal surface of the intestine, it will invariably excite its contraction, which passes upward towards the stomach, never toward the rectum. A test that will be of service in intestinal surgery.

A remarkable case of recovery from morphia poisoning has occurred at the Gouverneur Hospital. The patient, a young Spaniard, took no less than eighteen grains at a single dose, for the purpose of committing suicide. When he was taken to the hospital the respirations had become reduced to one a minute. Atropia and the cold douche were used with good effect in the treatment, which had to be kept up unremittingly for three days.—*Boston Med. and Surg. Jour.*

The first Medical Congress in the Mexican Republic will be held at Mexico from December 6th to 10th, 1892. The work of the Congress will be done in fourteen sections, as follows: Anatomy, Medicine, General Surgery, Syphilography, Neuropathology and Psychological Medicine, Ophthalmology, Surgery of the Urinary Passages, Therapeutics and Pharmacology, Obstetrics and Gynæcology, Hygiene and Bacteriology, Forensic Medicine, Military Medicine, Pharmacy, and Veterinary Surgery.

An officer of the police detail said recently: "When I was a mounted policeman I learned of a most humane and kind method of curing a balky horse. It not only never fails, but it does not give the slightest pain to the animal. When the horse refuses to go, take the front foot at the fetlock and bend the leg at the knee joint. Hold it thus for three minutes, and let it down and the horse will go. The only way in which I can account for this effective mastery of the horse is that he can think of only one thing at a time, and having made up his mind not to go, my theory is that the bending of the leg takes his mind from the original thought."—*Ex.*

B. Vespa has made a number of experiments as to the diuretic effect of lactose and glucose in various diseases. In the ascites of hepatic cirrhosis the diuretic effect was almost *nil*, and in acute and chronic nephritis it was hardly appreciable. In pleurisy with effusion, on the other hand, and in cardiac disease with disturbed compensatory action, the diuretic effect of lactose and glucose was most marked. As neither of these substances has any bad effect upon the heart or the nervous system they can be given at all times and in combination with any other remedy. They are well borne and do not cause nausea or other disagreeable effects.—Dr. Williams in *Boston Med. and Surg. Jour.*

Dr. Constantin Paul, of Paris, has been treating paralyzed patients by subcutaneous injections of a solution of the gray matter of the sheep's brain. This is, of course, a development of Brown-Séquard's experiments with testicular juice as a restorer of virile strength. A physician in this country has been using injections of double distilled extract of gonorrhœal pus in the treatment of rickety children whose fathers confessed to having had gonorrhœa in their youth. This is a fact. Then there is Koch's tuberculin. What are we coming to, any way? —*Med. Record.*

It has long been a problem how a battlefield on the night succeeding a battle could best be searched and stripped of its wounded. Many years ago an experiment was carried out at Aldershot with the electric light, and quite recently the Austrian medical authorities have been making similar experiments with the same end in view. It has been found that powerful search lights with reflectors are very effective aids where the country is open, but of comparatively little use where there are woods. An experiment has now been tried with portable electric lanterns, fed by accumulators, carried in the men's knapsacks. The men of the Army Medical Service conducted an experiment of this kind at Gratz, which is said to have been fairly successful, and is likely to be repeated.—*Ex.*

A malpractice suit has just been tried against a physician of Fishkill Landing, New York, with the result of awarding a verdict of $2,500 damages against him. Some time since, a draymen fell from his cart and broke his arm. The bone protruded from the flesh, and the wound was filled with dirt. It was dressed and looked after by the physician, but the patient found it necessary to enter St. Luke's Hospital, New York, after about a month, at which time the arm was swollen to double its usual size. When he left the hospital, the arm was useless and will always remain so. Suit was therefore brought for malpractice, the claim being made that the wound was not properly cleansed. The damages were laid at $5,000 and a verdict given for $2,500.—*Buffalo Med. and Surg. Jour.*

We learn from the daily "*Sun*" that the trustees of Bayview Asylum have appointed Dr. R. E. Garrett resident physician of the insane hospital, and Dr. W. Grove Harrison assistant. Both physicians were recommended by the faculty of the Johns Hopkins Hospital. Dr. Garrett has been assistant at Bayview for about a year. The salary is $500 a year for the resident physician and $100 for the assistant, both being furnished with board. The trustees some time ago passed a resolution to pay the resident physician a salary of $2,000, and Dr. Ingraham, of New York, was selected to fill the place. The council having passed an ordinance prohibiting any but residents of the city from being employed at Bayview, the board rescinded its former order and left the salaries the same as before.

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CONTENTS

ORIGINAL ARTICLES.

Symmetrical Corneal Ulcers Following Gonorrhœal Ophthalmia. By E. Oliver Belt, M. D., of Washington, D. C. 771

A Successful Case of Lateral Anastomosis of the Ileum for Malignant Stricture, with a Discussion of the Operative Technique. By William Easterly Ashton, M. D., of Philadelphia. . 773

SOCIETY REPORTS.

Clinical Society of Maryland. Stated Meeting held May 20, 1892 The Removal by Electro-Magnet of Fragment of Steel from Vitreous Chamber of the Eye. Treatment of Spinal Curvature by the Zander Method. Sea Tangle Tent Forced into Douglass' Cul de-sac in an Attempt to Produce Abortion. . . . 779

EDITORIAL.

The City Water Supply. 781

The Children's Country Home. . . . 781

School Examinations Abolished. . . . 782

REVIEWS, BOOKS AND PAMPHLETS. . . . 782

MEDICAL PROGRESS.

Paralysis of Diaphragm.—Chloroform Syncope Treated by Massage over the Heart.—The Lachrymal Puncta.—The Nerve Endings of Small Intestine.—The Immediate Causes of African Fever.—The Nature of Aural Polypi. Primary Vesical Tuberculosis Simulating Calculus.—The Simulation of Obsolete Tubercle and Tubercular Prostatitis. . . . 783

MEDICAL ITEMS. 791

Original Articles.

SYMMETRICAL CORNEAL ULCERS FOLLOWING GONORRHŒAL OPHTHALMIA.*

BY E. OLIVER BELT, M. D., OF WASHINGTON, D. C.

Ulceration of the cornea *during* an attack of gonorrhœal ophthalmia in the adult is the rule rather than the exception in neglected cases, and though in the case I now report one cornea was ulcerating when I first saw the patient, that which makes the case of peculiar interest is the fact that about four weeks after the beginning of the attack, after the discharge had been arrested, and the first ulcer had healed, and all ciliary and conjunctival congestion had subsided, there suddenly appeared a deep, clear ulcer extending horizontally across each cornea. The history of the case is as follows:

August 24th, 1891, I was requested by Dr. B. Ashbourne Capehart to see Miss F., aged 22, who had been brought back the evening before from the country, where she had been on a visit. Both eyes presented the typical appearance of purulent ophthalmia at its height. There was profuse discharge of pus with some blood from both eyes, the lids were much swollen and puffy, there was excessive chemosis, and the conjunctiva was deeply congested. The right cornea was clear, but the left was hazy and the upper portion was ulcerating. Vision in the left eye was reduced to the perception of light, and the prognosis for that eye seemed especially bad. The attack had begun suddenly one week previously, after having bathed her face the evening before with urine for

*Read before the Medical Society of the District of Columbia, May 25, 1892.

her complexion. Notwithstanding the attention given by the physician in the country the disease steadily advanced, and the eyes were in the condition above described, when first seen by Dr. Capehart upon her return to the city. The treatment was as follows:

For the chemosis very free scarification of the conjunctiva was made. The eyes were ordered to be thoroughly cleansed with hot water every hour, day and night, and a bichloride solution, 1–5000 used. Atropia solution, (grs. jv–℥j) was instilled three times a day, and nitrate of silver solution (grs. x–℥j) once a day. The discharge soon became less, but it was necessary to scarify the conjunctiva daily for about a week to relieve the chemosis. Eserine was used for a time instead of the atropia, and pyoktanin was substituted for the nitrate of silver. By the end of the second week the discharge had nearly ceased, ulceration of the left cornea had been arrested, and the conjunctiva was clearing. The improvement continued so rapidly that a week later, Sept. 17th, just a month from the onset of the disease, I visited the patient, thinking, perhaps, I could dismiss the case, when she complained that her eyes did not feel so comfortable, and hurt when she opened and closed the lids. I found a deep, transparent, wavy ulcer with sharply cut edges extending across each cornea, about the junction of the upper with the middle third. They were perfectly symmetrical in the two eyes, and appeared simultaneously during menstruation. There was no ciliary congestion, and very little photophobia. Eserine was prescribed, and ulceration of the left cornea was arrested in less than a week. Atropia was then used in that eye; the pupil dilated at first irregularly. The yellow oxide of mercury ointment was used once a day; this seemed to stimulate the left ulcer and repair was quite rapid; there was some conjunctivitis of that eye. The conjunctiva and sclerotic of the right eye remained clear, and the ulcer made no progress for several weeks. Occasionally it was touched with nitrate of silver stick. Pyoktanin was used quite regularly for a time. Atropia was used now and then to prevent iritis from the eserine, but the ulcer did not do so well when it was used. It was about a month before repair began in the right eye, and it progressed so slowly that it was three months before the ulcer had filled. At the present time her vision without glasses with the right eye is $\frac{20}{70} - \frac{20}{100}$ L. She has mixed astigmatism of about 3 D. in each meridian in the right eye, and 10 D. of myopia in the left, for which she had been wearing glasses before the attack of ophthalmia. It would be interesting to know the causes of these symmetrical ulcers, and of their simultaneous appearance so long after all active inflammation due to the ophthalmia had subsided.

Symmetrical ulcers sometimes occur during an attack of ophthalmia in the lower portion of the cornea, due, perhaps, to contact with the purulent discharge, and "there is a corneal affection peculiar to infants, which occurs when the discharge is getting scanty, or when too much nitrate of silver has been used, but in this form the cornea becomes quickly and almost entirely opaque throughout."*

Nettleship,† in speaking of "Exactly Symmetrical Corneal Ulcers," says: "The corneal ulceration in purulent ophthalmia is usually symmetrical and situated below the centre. Solitary phlyctenulæ, whether on the conjunctiva or cornea, are often symmetrically disposed on the outer, less commonly on the inner side of each globe. The corneal changes due to the friction of granular lids are almost invariably limited for some time to the part of each cornea, on which the upper lid lies. We sometimes, however, meet with quite symmetrically disposed

*Nettleship, Diseases of the Eye.
†Royal London Ophthalmic Hospital Reports, 1886.

ulcers of the cornea, due neither to the lodgment of purulent discharge on the lower part of the cornea, nor to exposure of the surface of the eye-ball, nor to friction by roughened lids.

"Thus, William R., 37 years, a cart driver, had, in July, 1884, a small well-defined ulcer at the junction of the upper with the inner quadrant, and midway between the margin and the pupil of each eye; the symmetry was precise. No foreign body nor other cause of local irritation could be found, but the man himself thought that the eye, which had been so bad for many weeks, had been inflamed by small 'green flies' getting into them. It is not likely that such cases as this, and others which could easily be quoted, are really examples of any general tendency to symmetrical disease of the cornea; probably all that they show is precise symmetry of the form and movements of the parts concerned."

Nothwithstanding the above assertion by Nettleship, it seems to me that there is a general tendency to symmetrical disease, not only of the cornea, but of other portions of the eye. A few weeks ago, in Dr. Burnett's clinic, I saw a boy with dense opacity of the lower half of each cornea perfectly symmetrical, from interstitial keratitis. I recall a case in my own clinic of extensive ecchymosis of the conjunctiva, exactly symmetrical over the external recti muscles. In keratitis punctata the peculiar triangular arrangement of the disease is frequently identical in the two eyes. Occasionally we see a corneal ulcer result from the presence of a foreign body in the conjunctiva. This is due to injury of the superficial branches of the fifth nerve, and I suggest that these cases of symmetrical ulcerations may result from a trophic or neurotic influence. However, in the case under consideration it is possible that the corneal ulcer may have been due to the presence of gonococci along the margin of the upper lid which corresponded with the location of the ulcer. May not the cornea have been able to resist the disease until its vitality was temporarily lowered by the occurrence of menstruation? This theory would also account for the simultaneous appearance of the ulcers.

A SUCCESSFUL CASE OF LATERAL ANASTOMOSIS OF THE ILEUM FOR MALIGNANT STRICTURE, WITH A DISCUSSION OF THE OPERATIVE TECHNIQUE.†

BY WILLIAM EASTERLY ASHTON, M. D.,
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I saw the patient, Mrs. E. C., for the first time on November 28, 1891, in consultation with her physician, Dr. Thomas Curry, of this city. She gave the following history: Twenty-eight years of age, and married nine years. She had had five children at term and two miscarriages. Three years ago, when five months pregnant, she fell from the window of the second story of her house, striking with her back and occiput upon the pavement below. This accident resulted in a slight uterine hæmorrhage, but the pregnancy was not interrupted, and she went to full term. Shortly afterward, however, she began to suffer from epileptic attacks. These continued up to eighteen months ago, since which time she has been entirely free from them. On August 20, 1891, she was delivered of a hydrocephalic child. The labor was natural, and was not followed by any puerperal complications. At this time she was in excellent health, and weighed 185 pounds. Shortly after getting up, however, her health began to rapidly fail.

†Read before the Philadelphia County Medical Society, March 9, 1892.

She began to have frequent attacks of violent abdominal and pelvic pain, preceded by the movement of gas in the intestines. Her abdomen was always greatly distended, which added to her discomfort. There was obstinate constipation, and the bowel movements could only be induced by purgatives and rectal injections. These movements were always small in amount, and caused a great increase in the abdominal pain and tenderness. She had constant nausea and vomiting and the abdominal distention was increased after taking food. She continued to lose weight and strength, and suffered from night-sweats. Seven weeks after her confinement her menstruation appeared, but it has not recurred since. Her weight at the time I first saw her had been reduced to 115 pounds.

On examination, I found that the abdomen was distended below the umbilicus. It had the appearance of a round tumor, filling the lower part of the abdominal cavity. The abdomen above the umbilicus, although distended, was not greatly so. Percussion gave a tympanitic note over the entire abdomen. No tumor could be felt on palpation. Indigation gave negative results. As I was unable to demonstrate by my examination the existence of a new growth, I looked upon the cause of the chronic obstruction as being due to intestinal adhesions, the result of a localized peritonitis. Cœliotomy was, therefore, urged, and consented to by the patient.

Operation.—Cœliotomy was performed at the Polyclinic Hospital on November 30, 1891, Dr. J. H. Gibbon, senior resident of the hospital, and Mr. Louis J. Borsch assisting in the operation.

Upon opening the abdomen, which was done in the median line below the umbilicus, the omentum was found adherent to and blocking up the entrance of the pelvic cavity. After freeing these adhesions, the pelvis was examined, and its organs found to be in a normal condition. The small intestines were greatly distended and adherent to each other at several points. These were then carefully separated. Up to this stage of the operation the conditions found seemed to confirm the diagnosis of an old peritonitis, resulting in intestinal adhesion. The existence, however, of the distention indicated a stricture at some point in the bowel, due either to additional adhesions or a new growth. With this view of the case in mind, the examination was carried still further, and resulted in finding a large cancerous mass situated in the ileum and involving the mesenteric glands. At this point the stenosis of the gut was so marked that it was with difficulty the gas could be pushed through it. As the cancerous involvement was extensive, any attempt at resection would have dangerously prolonged the operation without giving the patient the slightest chance of permanent relief. It was therefore decided to perform a simple lateral anastomosis without resection. Ten inches of the ileum on each side of the stricture were stripped of their contents, and a ligature of soft rubber tubing passed through the mesentery and tied around the gut at each end, to prevent the regurgitation of the intestinal fluids. The field of operation was then protected by packing carefully with gauze pads. Two openings into the intestine were then made, one upon each side of the stricture, and both about three inches distant. The excluded portion of the gut was then thoroughly irrigated through these openings. In making the anastomotic communication I used the solid rubber rings, and, to add further to the security of the parts, "the right-angle continuous suture" was carried entirely around the anastomosis. No irrigation of the abdominal cavity was employed, and the abdomen was closed without drainage. The entire operation lasted twenty-five minutes, and the patient was placed in bed with a good pulse and normal temperature.

After history.—The patient made an uninterrupted recovery, and was discharged from the hospital in twenty-eight days. The temperature was about normal throughout her convalescence, except on the day following operation, when it reached 100.4° F.; the pulse on the same day was 100 per minute—the highest number of beats during her stay at the hospital. A hypodermatic injection of morphine and atropine was given immediately after the operation, and on the second and third day, as the patient was somewhat restless. The patient for the first three days was nourished with nutrient enemas, and then food was given by the stomach. The bowels were freely moved on the fourth day, following the administration of calomel. There was no tendency to constipation at any time. The rings were passed on the eighteenth day. They were discharged whole, their segments not having become separated.

Immediately after the operation the abdominal pain and distention entirely disappeared and remained absent throughout her stay at the hospital. The patient vomited only once, and then on the twelfth day following the administration of salts. At the time of her discharge she had gained decidedly in weight and strength, and was free from all her former symptoms.

The patient was seen by Dr. Curry on the 24th of last February, three months after the operation. She had improved steadily in health; her bowels had moved naturally every day; there has been no vomiting, and the abdominal pain and distention had not returned. She had gained thirty-five pounds in weight since the operation. On the 10th of February her menses returned, after an absence of four months.

I shall pass at once to the discussion of some points of importance in the technique of lateral anastomosis.

The rings employed.—Those used in this operation were made of solid rubber cording, and were devised by Dr. Baldy and myself, and employed by us in our experiments upon dogs. The advantages of these rings have been fully discussed in our paper upon "Experimental Studies in Intestinal Surgery,"[1] and I shall not refer to them here. Recently I have modified these approximation rings, doing away, I believe, with the only real objection that could be advanced against them, namely, that they allowed too small an opening between the intestines. As I now make them they are oval in shape instead of being round, as they were originally. This is accomplished by means of a strand of catgut fastened across the ring at each end. They have six ligatures attached, in place of four: and the segments, of which the ring is composed, as well as the threads, are held by means of catgut. With a ring of this kind an anastomic opening may be made in the intestines, oval in shape, and having the following dimensions: $1\frac{3}{4}$ inches long, $\frac{1}{2}$ of an inch wide at the centre, and $\frac{1}{4}$ of an inch at either end.

Additional sutures about the anastomosis.—It is now generally held by operators that additional sutures about the seat of operation give greater security to the parts and lessen materially the dangers of leaking. For this purpose I employ the "right-angle continuous suture" of Cushing, using a simple knot for its beginning and ending, as advised by Keen, instead of the original complicated method. This suture may be introduced with great rapidity, and holds the serous surfaces together with accuracy. It is good practice to carry this suture completely around the anastomosis in order to be sure that there will be no leaking at any point.

Cleanliness during the operation.—It is impossible to do an ideal aseptic operation where the intestines have been opened. If, however, the parts be kept care-

1. Proceedings of the County Med. Soc. (Phila.), vol. xii., 1891.

fully cleaned, there will be practically but little danger of septic infection following. Those of us who do abdominal work must have frequently observed how quickly a blood-clot or other foreign material becomes adherent to the serous surface of the intestines, and with what comparative difficulty it is removed. No amount of subsequent irrigation will suffice to detach some of these adherent particles, and it is necessary to pick them off with the fingers. How easily, under these circumstances, a small particle of septic material may be overlooked and become the centre of an infection can be readily understood. To prevent the danger of this source of infection the seat of the operation should be frequently douched, during the operation, with warm sterilized water. This I believe to be a most important point in the technique of these cases. It certainly can do no harm, and it not only keeps the parts clean, but it at the same time lessens the dangers of shock by keeping the intestines warm.

Rapidity in operating.—In no field of surgery is time as important a factor for success as in abdominal operations. A surgeon may have the most profound knowledge of the subject, he may deal with all the accidents and complications which may arise with rare judgment and decision, and yet his results will be bad unless his operations are rapidly performed. Good results in abdominal surgery mean rapid work—that is, no shock, no ether-saturation. Park[2], in discussing those sources of septic infection not concerned in the wound itself, throws out a most valuable hint bearing upon this subject. He says: "There is good reason to think that chloroform and ether administered for some time may produce such changes in the blood and tissues that vital processes of repair, cell-resistance, and chemotaxis may be so far interfered with as to facilitate subsequent infection.

Feeding after operation.—The tendency of most surgeons to delay giving food by the mouth, and their reliance upon rectal feeding are, I am convinced, mistakes in the early after treatment of cases of anastomosis. If we employ, in our operations, rings which closely approximate the surface of the viscera and use additional sutures around the seat of anastomosis there can be no reason to doubt the security of the parts. It seems improbable, under these conditions, that the natural peristaltic action of the intestines would be sufficient to cause leakage. To throw light upon this question of early feeding after intestinal anastomosis, I shall refer to the following cases of gastro-enterostomy. Brookhouse and Taylor[3] report seven cases, with three recoveries and four deaths. In the cases which recovered, feeding by the mouth was begun on the second day. They considered early feeding as a most important factor in their successful cases. Page[4] reported a series of thirty-six cases with fifteen deaths, which were in most instances due to exhaustion. Beaston[5] reports two cases of very great interest as bearing upon the necessity for early feeding by the mouth. The first case did well immediately after the operation, but died on the fourth day from asthenia; food and stimulants were not given by the mouth until a few hours before death. The second case was extremely weak and exhausted at the time of operation, but, nevertheless, made a good recovery. This patient was given thirty drops of brandy every hour by the mouth as soon as he came out of ether, and next morning feeding by the stomach was begun. In his remarks upon these cases he says: "Do not place too much reliance upon rectal feeding. Food in small quantities

2. "Wound Infection," etc., American Journal of the Med. Sciences, Nov., 1891.
3. London Lancet, 1891, vol. i. p. 718.
4. London Lancet, 1889, vol. ii.
5. London Lancet, 1890, vol. ii. p. 761.

should be given early by the mouth, for in this way only can the tendency of death from asthenia be successfully combated." Jessett,[6] in speaking of the report of seven cases with two deaths, one on the sixth, the other on the seventh day, both being due to exhaustion, says: "Both would have recovered if fed earlier."

There can be no doubt that exhaustion is the cause of death in a large number of these cases as well as in anastomotic operations in other portions of the intestinal tract, and it is impossible, with rectal feeding alone, to prevent the fatal issue. In those cases which are seen early by the surgeon and are not exhausted, the question of early feeding by the mouth is not of first importance. On the other hand, however, cases which are weakened by the disease should be given food and stimulants by the stomach at the earliest possible moment after operation.

Closure of the anastomotic opening.—One of the gravest questions in intestinal surgery is the danger of subsequent closure of the artificial communication. This question cannot be settled until we have examined the seat of operation in a large number of cases which have recovered from the operation, but who have died subsequently at various periods of time. Although, as yet, but little has been done in this direction, still there have been a few such examinations made which may be referred to with advantage. Larkin[7] reported the results of a post-mortem examination upon a patient of his own, who died five months after he had performed a gastro-enterostomy for malignant disease. He found upon filling the stomach with water that it passed into the duodenum through the pylorus, but would not pass into the intestine through the artificial communication. After opening the stomach he failed to detect any trace of the anastomosis. He then opened that portion of the jejunum which had been attached to the stomach, and was able, with a fine probe, to pass into the latter. The malignant disease had not involved the seat of operation. Jessett[8] lost a case on the fifth day after performing a gastro-enterostomy, and found upon post-mortem examination that the artificial opening was quite patent and healthy, and that the bone plates were nearly digested. Sainsbury[9] lost a case on the second day after performing a gastro-enterostomy. The examination of the stomach after death showed a closure of the opening. He says: "The opening into the jejunum was patent when probed by the finger; but that there was an impediment, which must have been valve-like, is proved by the distended stomach, and the fact that water injected into the stomach before dissection did not escape into the jejunum." In this case rings or plates were not used, the anastomosis being made by a double row of sutures. Beaston[10] reports two cases upon whom he made post-mortem examinations following gastro-enterostomy. One of these patients died on the fourth day following the operation. He found the bone plates "greatly acted on by the digestive fluids, being reduced to the thickness of the thumb-nail and broken up into small pieces both in the stomach and bowels. The knots of the uppermost lateral threads were plainly visible, owing to the serous surfaces having fallen apart, probably on losing support of the bone plates." The artificial opening he found would admit the forefinger. The second case died in four weeks after section from acute lung trouble. The artificial opening was found to be oval in shape, with smooth and regular borders, and barely admitting the index finger. Keen,[11] in referring to a case operated upon by Dr. Abbe, in which a lateral anastomosis was made, says: "The open-

6. London Lancet, 1890, vol. ii. p. 68.
7. London Lancet, 1891, vol. ii.
8. London Lancet, 1890, vol. ii. p. 68.
9. London Lancet, 1891, vol. ii. pp. 18-20.
10. London Lancet, 1890, vol. ii. pp. 761-764.
11. Proceedings Phila. County Med. Soc., 1891, vol. xii. p. 93.

ing was large, and seemed ample. The patient died some months later, and it was found that the opening had narrowed and contracted so that ultimately there would have been complete obstruction."

In all the cases just mentioned the incisions into the intestine and stomach were ample, measuring from one inch to one inch and a half in length. With the exception of Dr. Abbe's case the bone plates were used in all of them.

There are several factors concerned in causing a narrowing of the artificial communication following lateral anastomosis. First, the natural tendency of the tissues themselves to retract; second, the contraction of the cicatrix following the healing of the incision; third, the direct union of a part of the incision due to the immediate contact of its edges; and fourth, the opening into the bowel not being sufficiently large or of a proper shape. The first of these causes cannot be avoided, as contractility and retractility are inherent properties of these structures. To prevent the contraction of the cicatricial tissue, Jesset[12] and Clarke[13] advise sewing together by a continuous suture, either of silk or catgut, the cut edges of the serous and mucous coats of the incised viscera. This brings the raw surfaces together, and is followed by direct union—an important fact, as it does away, to a great extent, with the formation of a cicatrix. This method of dealing with the edges of the incision will also prevent the danger of union from direct contact. Direct union of the cut edges of the bowel, as a cause of closure of the opening has, I believe, been overlooked by surgeons. Its importance, however, can hardly be questioned. For instance, the case of Larkins, quoted in this paper, goes a long way toward the support of this theory. For how else could we explain the fact that five months after section the opening only admitted a fine probe, unless we admit that in the beginning the edges became in part united. Again, Mr. Larkins performed a jejunostomy upon this very patient nine weeks after the gastro-enterostomy, on account of symptoms of closure of the artificial opening, and she was then kept alive by feeding directly into the jejunum. It is hardly likely that a large incision in nine weeks could become closed by the retraction of tissues and the contraction of the cicatrix alone. Furthermore, Beaston's two cases both point in the same direction—one of them dying on the fourth day, and the opening only admitting the forefinger, while the other barely admitting the index finger at the end of one month. In all of these cases long incisions were made, and their rapid narrowing certainly teaches us a lesson. I do not for one moment wish to be understood as stating that direct union of the edges is the only factor in the case, but I do wish to emphasize its importance as a cause. Dr. Keen[14] has made a suggestion of great practical value in the technique of lateral anastomosis. He advises, instead of making a simple slit, to pinch up the bowel and remove an oval piece. This plan, he believes, would lessen the danger of contraction taking place. While I do not believe that this suggestion would in any way lessen the amount of contraction, I do believe that it would, by lessening the danger of direct union of the cut edges, prevent to a great extent the tendency to closure. Another point of importance is, as suggested by Jessett, to pass the lateral sutures of the ring as close to the edges of the opening as is consistent with safety. In this way the edges of the incision are kept wide apart. The length of the incision for an anastomosis should be from one and a half to one and three quarters of an inch. An opening of this size, made oval in shape and having its mucous and serous

12. Brit. Med. Jour. Lond., 1891, Vol. i. p. 1377.
13. Brit. Med. Jour. Lond., 1891, Vol. i. p. 798.
14. Proceeding Phila. County Med. Soc., 1891, Vol. xii. p. 93.

edges united by a continuous suture, offers, I believe, the best chance of remaining permanently patent.

My experience has been that it is extremely difficult to cut out an oval piece of gut with scissors, as the opening is apt to be irregular or larger than we desire. I saw a well-known operator make this mistake, and he was obliged to narrow the opening by stitching it across with catgut. To overcome this difficulty I have devised a steel punch for the purpose. With this instrument we are able to make the opening of a definite size and its borders clean and sharp—factors of great importance. The incision is oval in shape, one and three quarters of an inch wide at its centre, and one-quarter of an inch across at each end. By having the ends of the opening abrupt instead of tapering, there is less danger of direct union.

In conclusion, I desire to call attention to the following points:

1, The necessity of frequently douching the seat of the operation with warm sterilized water to prevent the dangers of infection and shock.

2, That rapidity in operating is of great importance for success.

3, That early feeding by the mouth should be employed in all cases, especially in patients who are weak and exhausted.

4, That early feeding by the stomach does not add to the dangers of leaking, as the parts are perfectly secure, if proper rings and additional sutures are employed.

5, That an important factor in causing subsequent closure of the anastomotic opening is a direct union between the edges of the incision.

6, That the danger of subsequent closure of the artificial communication is materially lessened by using a steel punch in making the opening: by stitching the edges of the serous and mucous coats of the bowel together; by placing the lateral sutures of the ring as close as possible to the margins of the incision; and lastly, by making the anastomotic opening sufficiently long and of an oval shape.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD MAY 20, 1892.

The 267th regular meeting of the Society was called to order by the President, Dr. Robert W. Johnson.

Dr. Samuel Theobald related "A Case in which the Electro-Magnet was Employed Successfully for the Removal of a Fragment of Steel from the Vitreous Chamber of the Eye."

A lad, twelve years of age, while using a hammer, struck a small piece of steel, which penetrated the eye and lodged in the vitreous chamber. The case was first seen six days after the accident. The fragment penetrated upper margin of the cornea; just in line with this was a hole through the iris as large as a small pinhead. The eye was markedly injected, with evidences of perhaps commencing iritis. In vitreous humor, diffused opacity and numerous floating opacities. There was a punctate opacity on the anterior surface of the lens where it had been touched by the foreign body. Details of fundus could not be seen. The foreign body was not visible. Vision $\frac{1}{6}$ths. Operation five days after the patient was first seen, or eleven days after the accident. The injection increased, and iritis had begun. Incision about 4 m.m. in length through the sclerotic between the external and inferior rectus muscles. A Hirshberg's electro-magnet was employed. A single cell of the battery was used; this enabled the magnet to lift up a tack-

hammer. The point of the magnet was introduced well into the vitreous humor three or four times without success, but finally it brought out the little particle of steel the size of a pin's head. The conjunctival wound was stitched, and an opium and boracic acid lotion with compress was used. Atropia kept the pupil dilated. Boy suffered very little. Seventeen days after the operation he left hospital, at which time the injection was very much less, the vitreous had cleared up very materially and vision was ⅓ths. At present time, 44 days after operation, the fundus of the eye can be seen with perfect ease. There are one or two floating opacities in the vitreous humor. Vision ⅔ths.

Dr. Robert Randolph: This is one of a very large class, forming the larger number of cases which come to us for enucleation, and the larger number which end in sympathetic ophthalmia. We have here a better method of dealing with such cases, when we have a reasonable idea of the location of the foreign body, and under strict antiseptic precautions the operation is indicated and there are a sufficient number of cases on record to justify us in looking for a happy issue.

Dr. Kate Campbell Hurd read a paper on TREATMENT OF SPINAL CURVATURE BY THE ZANDER METHOD.

Dr. J. H. Branham reported a case in which A SEA-TANGLE TENT WAS FORCED INTO DOUGLASS' CUL DE-SAC IN AN ATTEMPT TO PRODUCE ABORTION.

On February 27th, 6 P. M., saw in consultation a young married woman of 24; mother of three children; had been about two months pregnant and had attempted to produce abortion on herself with sea-tangle tent three days before I saw her. After leaving it for 24 hours she tried to remove it, but simply pulled out the string. Next morning her physician was summoned, but failed to find the tent, although the uterus was partly dilated and from it issued a bad-smelling discharge. When I saw her, her temperature was 103, pulse 120, abdomen very much swollen and exceedingly tender. The finger could be introduced into the uterine cavity, but no tent was found. An opening in the wall of the cervix was discovered and through this the tent was felt in Douglass' cul-de-sac. It was removed through this opening and was found to be about the size of one's little finger. An opening was made into the cul-de-sac and a drainage tube put in.

The uterus and vagina were washed out with 1-4000 bichloride. There was a temporary improvement, but she finally died 36 hours after I first saw her.

The woman maintained to the last that she introduced the tent herself, and this is probably true, considering the direction in which it was forced.

1519 N. Broadway. W. T. WATSON, M. D., Secretary.

With reference to Dr. A. Milne's note on "Strychnine as a Prophylactic in Chloroform Poisoning," I have been in the habit, for some time past, of giving 15 min. of tinct. nucis vomicæ about a quarter of an hour before commencing the administration of either ether or chloroform, always taking care that the patient should not take any food for three hours previously. I have every reason to believe this practice to have been attended with beneficial results.

The idea was suggested to my mind by reading a report, I think by the Indian Commission, in which both tincture of nux vomica and digitalis were spoken of as the best medicaments to be used in apprehended death. From a "remedy" to a "prophylactic" was not much of a mental step, hence its use by me as such. —Dr. Wiglesworth, *Brit. Med. Jour.*

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BALTIMORE, JULY 2, 1892.

Editorial.

THE CITY WATER SUPPLY.

The warnings which have frequently been sounded concerning the danger of pollution of Lake Roland by the drainage of the dwellings and stables on its shores are at last receiving some attention from the city authorities. In view of the opening for settlement of the new suburbs known respectively as Ruxton Park and Ruxton Heights, and of the already existing dangers arising from the drainage of Ruxton and of certain parts of Towson directly into the lake, it is evident that something must be done soon to secure the purity of this city reservoir.

Especially is Ruxton Heights to be considered in this particular, since its lots are to be sold to persons of moderate means; so that there will soon be a closely built village of small houses on this slope which drains into the lake.

What ought to be done, we may leave to the decision of the proper authorities, but it is evidently high time for the city and county health boards to be putting their heads together over it.

The dangers of pollution from the presence of the boating club-houses on the lake are infinitesimal. Privies and stable-yards are what the authorities should consider.

THE CHILDREN'S COUNTRY HOME.

Wednesday, June 22, was Donation Day at the Home; and the number and bulk of the donations attested the interest which the citizens of Baltimore take in giving the boys and girls of its smaller streets and alleys a taste of the real country.

The Home is a healthy country place among the hills between Catonsville and the main stem of the Baltimore and Ohio Railroad. It it managed by well-known

ladies of Baltimore, and is in immediate charge of the "All Saints" Sisters of the Episcopal Church. It has accommodations for forty children at a time; boys from 3 to 8 years of age being received one month, and girls from 3 to 12 years the next.

Suits of clothes are provided by the managers during the visit. Last year two hundred children received a vacation of two weeks or longer.

Persons desiring to send children should mail the request, giving full name and address of the children, to Mrs. Edward R. West, Catonsville, Md. When such requests are received a member of the society visits each of the applicants; and, after examination by the attending physician, Dr. Charles O'Donovan, they are sent out to the Home.

It is said that the absence of the children who are at the Home under the excellent care of the Sisters is highly appreciated by some of the mothers who are worn out with family cares.

SCHOOL EXAMINATIONS ABOLISHED.

It is well-known that the strain of severe school examinations is very great in the case of certain sensitive and ambitious scholars. Now and then a death from typhoid fever following close upon the June commencements is, with much reason, traced back to the anxiety and mental strain of the examinations; a view intensified in the minds of the patient's relatives by the fact that the patient in periods of delirium goes over and over again the themes of the examination week.

It is, therefore, with great pleasure and interest, that we learn of an effort on the part of our public school board to do away with unnecessary examinations. The annual examination for promotion from class to class in the primary and grammar schools, and for promotion from primary to grammar schools, is to be abolished. The teachers of the school will now decide who is fit to be advanced. Dissatisfied pupils may have an examination if they ask for it. Promotions from grammar schools to the city college and high schools have for years been made on this plan, which has worked very well.

Apart from the benefit which the pupils will receive from the new rule, we may be sure that it will afford great relief to teachers. The conscientious oral examination of fifty odd pupils on a day when the temperature is up to ninety is an enormous strain upon the teacher.

Reviews, Books and Pamphlets.

Surgical Handicraft. A Manual of Surgical Manipulations, Minor Surgery, and other matters connected with the work of House Surgeons and Surgical Dressing. By WALTER PYE, F. R. C. S., Surgeon to St. Mary's Hospital, and the Victoria Hospital for Sick Children; late Examiner in Surgery in the University of Glasgow. Upwards of 300 illustrations on wood. First American Edition, from the Third London Edition, revised and edited by T. H. R.

Crowle, F. R. C. S., Surgical Register to St. Mary's Hospital, and Surgical Tutor and Joint Lecturer on Practical Surgery in the Medical School. 8vo. Pp. 600. Cloth, $3 50, net; Leather, $4, net. New York: E. B. Treat, publisher, 5 Cooper Union.

In this handy volume the author has endeavored to describe the details of surgical work as it appears from the point of view of house surgeons and dressers in surgical wards. His incentive is the belief that the manipulative side of surgery is receiving too little attention at the present day. The American reader will miss some familiar methods of treatment; as, for instance, the use of hot water to check certain form of hæmorrhage. The early necessity for the issue of a new edition speaks well for the general merits of the book.

Medical Progress.

PARALYSIS OF DIAPHRAGM.

On account of its great clinical interest we extract the following article, by Dr. Suckling, unabbreviated, from the *Brit. Med. Jour.:*

Paralysis of the diaphragm is a rare affection, but in my opinion is frequently overlooked, though it may be easily detected if searched for. During the past year I have met with six cases. The first case, which I saw with Mr. Stanley, of Small Heath, was that of a young gentleman who had strained his neck over a horizontal bar in an athletic display. Within an hour he complained of numbness and weakness of his legs, and when I saw him these symptoms had increased. He had difficulty in swallowing, and scarcely any power of phonation. I found paralysis of the right half of the diaphragm, the left half acting but feebly. By keeping the patient absolutely at rest, and by careful feeding, with frequent applications of a faradic current to the right phrenic nerve, the patient was kept alive. The diaphragm gradually recovered power, and in six or seven weeks he was quite well. The lesion in this case was probably hæmorrhage around the cord above the origin of the phrenic nerve, the pressure being greater on the right side.

The second case, which I saw with Mr. Hall-Edwards, was that of a young lady who was suffering from influenza, and I was called in on account of severe neuralgic pain in the right lower extremity. The pain was paroxysmal, and of such severity that morphine injections had to be given constantly. On my second visit I found the right half of the diaphragm paralysed. There was no dyspnœa and no alteration of the voice. We decided to apply a faradic current to the phrenic nerves, one pole being placed at the lower end of the anterior triangle in the neck, the other over the hypochondrium. The patient improved with this treatment for a day or two, and then died quite suddenly. This was in my opinion a case of acute multiple neuritis, and the paralysis of the right half of the diaphragm was due to neuritis of the right phrenic nerve, the implication of the left nerve being the probable cause of sudden death.

The next three cases were all due to diphtheria, and were all fatal. I believe that paralysis of the diaphragm is the cause of the great majority of sudden deaths after diphtheria, and that only a few can be attributed to syncope. I believe also that in many cases the diaphragmatic paralysis is not recognized. Of the three cases one was a man and the other two children. In all the cases paralysis of the legs was present, and there was no difficulty in recognizing the

diphtheritic origin of the mischief, though in one case the sore throat had been very slight. While at rest in bed there was no dyspnœa, but phonation was very feeble and defæcation and micturition impeded. On examination of the abdomen the diagnosis was readily made. The hypochondrium on the affected side became depressed on inspiration instead of being propelled forwards, and by placing the hand under the ribs the non-descent of the diaphragm could be easily ascertained. There was compensatory overaction of the lower intercostal muscles and great enfeeblement of the breath sounds at the base of the lung on the affected side. In each case the right half of the diaphragm was chiefly affected, but I believe this is due to the presence of the liver on this side and to the inability of the weakened muscle to push the organ down, while on the left side the muscles can descend until quite paralysed.

In all three cases the paralysis was recognized a day or two before death, and special precautions taken, but in each case death occurred quite suddenly. One little boy was brought to my consulting room; observing the feeble cough and phonation, I had him stripped and examined the diaphragm: I found it paralysed. This enabled me to caution the parents of his grave danger, and I heard afterwards that he died suddenly the day after seeing me. If both halves of the diaphragm become paralysed, death ensues from asphyxia, and the fatality of diaphragmatic paralysis after diphtheria can easily be understood when we remember the severity of the neuritis which frequently follows diphtheria, some patients being paralysed for a year or more.

As to treatment I would recommend that every case of diphtheritic paralysis be kept in bed from the first, and that plenty of nutritious food be given. Iron and strychnine should be administered in large doses. If weakness of the diaphragm is observed the patient should be raised in bed with pillows, so that the diaphragm may act more easily. A gentle faradic current should be used three or four times a day, and blistering fluid painted over the course of the phrenic nerve in the neck. Stimulants should be given freely.

The prognosis of paralysis of the diaphragm after diphtheria is very grave, and its onset may be possibly prevented by keeping patients in bed and at rest whenever any signs of paralysis are present. The early recognition of paralysis of the diaphragm is very important from a prognostic point of view.

The sixth case was that of a woman, aged 37, who was admitted for a second attack of alcoholic paralysis. The hands and feet were dropped, and the usual symptoms were present in a typical manner. The diaphragm was observed to be paralysed, and the patient died suddenly a day or two after this observation. I am not aware that paralysis of the diaphragm has been previously observed in alcoholic paralysis, or that it has been noted as a cause of sudden death, most of such deaths being attributed to cardiac paralysis. This case emphasizes the great similarity that exists between alcoholic and diphtherial paralysis, and as alcoholic paralysis is recognized as being due to multiple neuritis, the paralysis of the diaphragm being also due to neuritis of the phrenic nerves, we may reasonably infer that paralysis of the diaphragm after diptheria is also due to neuritis of the phrenic nerves. In none of the above cases could a *post-mortem* examination be obtained.

CHLOROFORM SYNCOPE TREATED BY MASSAGE OVER THE HEART.

It would seem that the conflict between those who claim that death by chloroform is always through suspension of respiration, and those who claim it to be due to syncope, is irrepressible and will never get its quietus.

Many surgeons grow angry if an assistant presumes to feel the pulse of a pa-

tient under chloroform, while many others study the behavior of the heart under like conditions with anxious solicitude.

It was thought that Dr. Brunton, through the experiments of the Hyderabad Commission, had settled the question for good and all on the side of respiratory suspension; but such paragraphs as the following are likely to cause the heart-failure parties to the controversy to take heart again, and to insist that the pulse shall be carefully studied in all patients under chloroform:

"Maas (*Berlin. Klin. Woch.*, No. 12, 1892) reports two cases in which patients, apparantly dead from chloroform syncope, were resuscitated by simple compression in the region of the heart. In both cases respiration and radial pulse had entirely stopped and the pupils had dilated. The manipulation of the heart was in both cases carried out for over an hour. As a result both patients suffered from mental derangements, difficulty in swallowing, and in speech, all of which passed off very slowly. The manipulation was conducted as follows:

"The operator, standing upon the left side of the patient, pressed with quick, strong movements deep down in the region of the heart with the fingers of the right hand, while the ball of the thumb was placed above the left clavicle. The number of compressions was 120 or more a minute. The left hand should seize the patient on the right side of the thorax. Soon after beginning these compressions the pupils became smaller and the paleness of the face disappeared."—*Amer. Prac. and News.*

THE LACHRYMAL PUNCTA.

In the *Medical News*, June 25, Dr. George M. Gould writes thus of the functions of the punctum:

It should not be destroyed except from imperative necessity. I have elsewhere noted the reckless and stupid haste with which the function of the punctum is forever destroyed by the customary treatment of epiphora, lachrymal conjunctivitis, dacryocystitis, etc.

It has been long known that the punctum is surrounded by a series of muscular fibres that have precisely the action of a sphincter. This may be demonstrated by inserting a bristle or fine probe into the orifice, when the force with which the foreign body is grasped may be distinctly felt. Dust-particles pass *below* the punctum, their gravity aiding to keep them away from the opening of the punctum. The lower punctum being at the very upper border, drains off only the upper and purer part of the little lake of tears, the action of the lids and of the excess of tears washing the foreign bodies easily past the punctum to the inner canthus.

In eyes that are inflamed, the concrete exudate, both in waking and after sleep, is gathered at the inner canthus, having passed by the punctum. The same fact is observed when black dust in the eyes has been excreted by the action of the lids: it is found gathered in a little ball at the extreme inner angle of the lids. By its exquisite mechanism the eye has most dextrously rid itself of the rubbish; and in doing so this has not been dumped into the capillary tubes of the canaliculus or duct. Had this, through a large patulous opening, taken place, the foreign bodies, however tiny, either mechanically by gathering and thus clogging the tiny canal, or by the reaction of the resultant irritation or inflammation, would often have closed the excretory passage-way, producing the well-known symptoms of lachrymal retention, etc.

It would therefore appear that the sensitive sphincter and punctum constitute a willing gateway for the excretion of pure tears, but a careful guard or sifter-out

of dust, irritating particles, and such viscid products of inflammation as would in any way produce stenosis of the connecting drainage-system lying beyond and below. The fact would argue for the theory I have advocated as regards the non-action of antiseptics upon the gonococcus in the canaliculus, sac, etc. Not only is pus a foreign body, but probably the irritation of the brush employed in making applications, etc., acts as an excitant to punctum-contraction. It would also and especially emphasize the value of other methods than those of entire destruction of the sphincter ed punctum, in the treatment of functional or temporary lachrymal obstruction. In these days, moreover, of manufacturing and urban life, with an atmosphere increasingly thick with dust, it behooves us to pay particular attention to the preservation of a structure and function so beautifully purposive and so effectively useful to the eye.

THE NERVE ENDINGS OF SMALL INTESTINE.

Dr. Henry J. Berkley contributes a short paper to the *Johns Hopkins Hospital Bulletin* for June, from which we extract a few paragraphs:

I am not yet prepared to speak with any certainty of the probable results of the reduction of the silver salt in the layers beneath the muscularis mucosæ, for this reduction has always proved to be very incomplete, and but fragmentary details have been seen, and any deduction from them might prove to be entirely incorrect and have to be withdrawn: accordingly I will leave that portion of the intestine for a future communication, only mentioning that in the outer muscular coat of the mouse there is an exquisitely developed plexus of fine and coarse fibres with a general direction parallel to that of the muscular band.

In that portion of the submucosa subjacent to the muscularis mucosæ, reductions have been obtained with moderate constancy, and the nerves are there to be seen running in bundles of two or more, upon or around the blood-vessels as they enter the granular layer, and entering the muscularis mucosæ with them.

It is vastly more troublesome to trace the nerves from their commencement in the submucosa through to the end-knobs, than to discover these end-terminations; a difficulty not due in any measure to the course of the nerves themselves, but to the extreme irregularity with which a perfect reduction of the silver salt is to be obtained; the method being by far the most onerous and uncertain I have ever used, and particularly so with the intestine. Almost hourly the specimens have to be watched, tried and tested: then after the utmost care, the slightest under- or over-hardening destroys all hopes of any result.

As has been already mentioned, the nerves in the muscularis mucosæ seem almost invariably to follow the blood-vessels in twisted bundles of two or more; the majority of them pass on to the mucosa, but here and there a curious deviation occurs: from the nerve-bundle three or four dotted lines arise, which continue between the muscular bundles and form a spray, terminating for each dotted line in a very minute knob, the figure bearing some remote resemblance to the nerve-end terminations in the tendons as described by Golgi. Rather more rarely the spray of dotted lines does not terminate in minute single bulbs, but joins together in a spherical figure, which is apparently inclosed in a transparent capsule. The contents of this sphere consist of a number of irregularly shaped particles with a transparent substance intervening between them. It has been suggested to me that both these figures were the same, only that the end-bulb had been severed in one case and present in the other. I am inclined to dissent from this view, as the knob-ending does not usually occur except where the nerve terminates, and hence regard both as essentially different endings.

The fibres that pass beyond the muscular band of the mucosa show a prefer-

ence for ascending toward the free surface of the intestine on the villi; few rise for any distance on the follicles of Lieberkühn, then only to pass off to a villus. At the base of the villi there may be only a single fibre or several together, but in either event they soon begin to ramify and split up, spreading out from the blood-vessels, or following closely their sheaths; again separating from them, and at the same time giving off branches that ascend or descend as the case may be: finally the main stem usually ends in or close to the epithelial lining of the villus, in one or more end-knobs. These knobs vary slightly in appearance, the most frequent form being a simple ball, or, less frequently, an elongated swelling.

The nerve supply to the follicles of Lieberkühn is apparently solely derived from the side-twigs of the stems that ascend with the villi. These fine twigs seemingly penetrate between the glandular epithelium of the follicles, and there end in a manner I have so far not been able to determine with certainty. It is positive, though, that between every epithelial cell there is not a nerve-twig, but only here and there between them, illustrating what is no longer a theory, that the nerve force is not conveyed to the cell by direct contact, but rather through contiguity, this being the case both with the central and peripheral nervous systems.

All the nerves of the mucosa intestinalis are exceedingly fine, and apparently are entirely without medullary covering.

I have so far made no detailed study of the nerves of the kidney; the few specimens obtained after much trouble show them in large numbers in every part of the cortex, the larger stems coursing between the tubules, the finer ones anastomosing in every direction. They present the ordinary characteristics of the terminal nerves as stained with the silver salt.

THE IMMEDIATE CAUSES OF AFRICAN FEVER.

From a graphic article on this subject in the *Lancet*, May 28, by Surgeon Parke, the companion of Stanley, we clip a few sentences:

Perhaps the sharpest febrile attack experienced during this part of the journey was my own, which commenced on April 18th and lasted for a week. It followed a "ducking" which I received in crossing a tributary of the Congo. I had tried to escape a wetting by riding my donkey through the water, but the animal slipped accidentally and completely submerged me. This was but the first of a long series of experiences, in which I found that every wetting in equatorial Africa—whether that of an accidental bath, like the one just referred to, or received in quietly wading a stream or swamp, or exposure to a drenching tropical shower—meant a subsequent attack of intermittent fever. Another lesson soon learnt, and for which I was still less prepared, was the fact that our donkeys after each corresponding drenching developed febrile symptoms exactly corresponding to those of their human fellow-travellers. After wading or swimming a stream of considerable size each of our poor quadrupeds became sick and dispirited, with drooping ears and "staring" coat, rapid arterial pulsation, and high internal temperature. These phenomena recurred with monotonous regularity. The white officers of the expedition fared similarly. Each immersion was followed by fever; so was each exposure to a chilling breeze, during or soon after active perspiration. So was direct and prolonged exposure to a very hot sun if the head and spine were not sufficiently protected. All such pronounced oscillations of the external temperature were followed by the phenomena of suspension of the functions of the heat-regulating mechanisms.

We are still far from having arrived at any degree of certainty regarding the connection between the micro-organisms which have been discovered in the circu-

lation, and the pathogenesis of disease whose phenomena appear to be accompanied by their presence. Why it is that a couple of hours' unshaded exposure to a vertical sun, a single hour's chill, the swimming of a river, the wading of a swamp, and the quiet inhalation of the vapors arising from a quantity of the rank and moist decomposing vegetable products of the soil, were all rapidly followed by similar trains of symptoms in ourselves and our quadrupeds, is a question which has not, I think, been definitely solved by the results of bacteriological investigation up to the present date.

THE NATURE OF AURAL POLYPI.

The word "polypus" is of great antiquity in medicine; for this reason we still retain it. The name is by no means a good one, because the growths to which it is applied have usually a single stalk, are pedunculated, and quite devoid of "many feet" or protruding processes, like a fresh-water polyp. It may be generally stated that any growth of a canal, or cavity of the body, which becomes pedunculated, and attached to the surface from which it springs by a stalk, is called a polypus. Thus we have polypi of the nose, of the rectum, of the bladder, and of the uterus. This word, also, does not give us any idea of the exact structure of the growth, which, indeed, may be diverse in nature. These tumors, growing as they do without infiltration of the tissue from which they arise, are not malignant; but this rule is not devoid of serious exceptions, as we find if we study the literature of polypoid growths, in various situations. Much mystery has been attached to the consideration of polypi of the ear, as though they were of a quite exceptional nature. The pathology of them is a matter of no extraordinary difficulty, but the treatment is always complicated, and often not unattended with risk to life. I believe that the majority of aural polypi grow from within the tympanic cavity, and have their origin in the constant irritation of a focus of necrosis. The carious bone may be on the superficial aspect of the tympanic walls or it may be in the mastoid or other parts of the temporal bone; the polypus then springing about the orifice of the sinus by which the disease communicates with the tympanic cavity. It must early be recognized that these growths have their origin in perforative otorrhœa, neglected and of long standing. They protrude through the aperture in the drum, and are moulded as they grow by the walls of the canal into polypoid form. Aural polypus would not be so common a disease if the treatment of otorrhœa was commenced early and persistently and carefully carried out. Polypi also originate from the walls of the auditory canal; here they may be caused by a "spot" of caries. They may originate round the orifice of a sinus, or they may have their starting point in the constant irritation produced by the flow of foul and irritating pus. I have examined with the microscope a large number of aural polypi. They are composed of simple granulation tissue covered with epithelium, and there is no essential difference between the structure of a soft, florid, aural polypus and the fungous granulations that are seen about a sinus leading down to a diseased femur or a necrosed jaw. Its form is merely determined by the confined conditions in which it grows. The more rapidly the polypus increases, the more it is encouraged by the injudicious warmth and moisture of poultices and fomentations, the softer it will become. Its structure will then be almost myxomatous. Aural polypi which have grown slowly and lasted long will be fibrous in consistence, and covered on the surface by well defined flattened epithelium. Different names are given to varieties of aural polypi derived from their consistence and color. Such are the "raspberry polypus," soft and friable, the "œdematous polypus," the "gelatinous polypus," and others. For

purposes of practice, however, it is far better to look upon these growths as representing embryonic tissue in different stages of development.

In rare cases polypi are extremely vascular, large quantities of blood flowing from the ear when they are in any way intefered with; to this variety the name of "angiomatous polypus" is applied. True sarcomatous polypus is exceedingly rare. It is difficult, if not impossible, for the most experienced histologist and pathologist to certainly distinguish by the microscope between embryonic granulation tissue and rapidly growing sarcoma. The structure of both may be identical. Accordingly, when these growths were removed, and recurrence took place, it was frequently assumed that this recurrence was due to some inherent malignant qualities in the growth itself; the fact that recurrence of the growth was dependent upon the persistence of the local conditions that originated it was lost sight of. In a recent issue of the "Archives of Otology" I have related a case of this nature which is of very great importance. The polypus in this case was microscopically pronounced to be sarcoma by one of the best pathologists in this country; but the results of operation make me tolerably certain that it is not so, but that the growth was luxuriant granulation tissue dependent upon a fistulous sinus, from the mastoid to the bony canal, near the drum.—From a lecture by Dr. Shield, *Lancet*, May 28, 1892.

PRIMARY VESICAL TUBERCULOSIS SIMULATING CALCULUS.

In a very interesting lecture on the "Mimicries of Primary Urinary Tuberculosis," Dr. Fenwick (*Brit. Med. Jour.*, May 28, 1892) remarks:

The efflorescence of the first patch of primary vesical tubercle or the first appearance of the track of the invading ureteric or prostatic contagion can be readily and distinctly seen with the electric cystoscope. With the latter sources of invasion we have not to deal at present, beyond mentioning that in each of these separate conditions the portion of the bladder first affected is different. Primary vesical deposits usually appear first upon the posterior wall. Ureteric invasion shows itself first at the ureteral orifice and along the corresponding outer limb of the trigone. Prostatic deposit creeps in at the the urethral opening and spreads itself out uniformly in the trigonal submucous layer. The symptoms of primary tuberculosis are very characteristic. A young male, 16 to 25 years of age, often without any venereal history, with a family tendency of tubercle, suddenly experiences a pain in the glans or mid-penis whilst urinating. There is an almost immediate increased frequency of micturition in the day. Soon the night is much disturbed by constant calls to empty the bladder.

These symptoms are followed in a variable time, according to the acuteness of the disease, from a few days to a few months, by the appearance of blood in the urine. The blood is often profuse and very bright at one time or other in the course of the early stage, from sloughing out of the deposits; but these attacks are for the most part transitory, and the patient usually only sees a few drops of blood follow the end of the stream of urine, strained out as it were by his effort to get rid of "something." I am quite aware that upon the symptomatology of this and of other sections of urinary tubercle you are taught differently; but you must realize that in precystoscopic times there were no means, except by rare *post-mortem* examination, of checking our knowledge of the course of the symptoms step by step as they arose. In 76 per cent. of the cases, frequency of micturition and penile pain are the first symptoms, but in the smaller number, in which I suspect a secondary vesical deposit from an extraurinary focus sloughs out, hæmorrhage is the onset symptom. The stream of urine is often arrested, but if you inquire carefully into the cause for this you will find that the patient checks it

voluntarily on account of the pain: the sudden cessation, therefore, is not due to the abrupt corkage of the urethral orifice with a stone.

After a few months the bladder becomes contracted so that it cannot contain more than 6 or 8 ounces, and so marked is the distention reflex, that the patient will often kick or groan even when the corneal reflex has been abolished by ether, if the bladder is forced by syringe pressure to contain more. The urine from the very first contains traces of pus, and this increases rapidly to a thin but distinctly visible deposit. It is more or less murky, of a light color, of normal specific gravity, and it remains acid until the surgeon makes it alkaline by interference. At first there are all well marked periods of quiescence, often for a fortnight or more at a time, and in these periods the irritability, pain and blood disappear, or nearly so.

From this you will readily understand that to a superficial observer the symptoms of primary vesical tuberculosis are very much like those of stone in the bladder. We encounter the same irritability, the same glans pain after urination; the blood, pus, and murky urine; the stoppage in the stream, and the periods of quiescence in both. There are, however, points of difference both in the patient, his symptoms, and his urine, which will at once lead you to doubt the existence of stone. His youth, his family history, the distressing irritability of the bladder at night, the sudden and causeless appearance of bright hæmaturia not increased by exercise nor checked by rest, the sudden relief of the suprapubic pain and the rapid disappearance of the glans pain after the evacuation of the bladder; the persistent post-scrotal pain; the very light, acid, murky, scentless, puriform urine which is passed at the very outset of the trouble; and, finally, the periods of quiescence being uninfluenced by violent exercise, point to the tuberculous and not to a calculous nature of the disease.

Septic infection and excessive zeal sum up the dangers of injudicious treatment. I will admit that, for one not using the cystoscope, the sound in doubtful cases is most necessary. Let me, however, urge on you all possible gentleness and cleanliness in sounding. Tubercle resents the slightest manipulative roughness. Put your patient to bed, boil the sound, use it well warmed and oiled, and with as light a hand as possible. I have already mentioned the danger of introducing septic material in washing out the bladder. No antiseptic wash will help you to stamp out tubercle. Germicides will only increase the cystitis and widen the field for invasion. Iodoform has no curative powers. Washing out the bladder with boiled water will relieve the pain in the early stages, and often check the blood. Above all things do not explore digitally and then salve your conscience with the assumption that the drainage will do good. Drainage gives no permanent relief unless the tubercle is removed, and it very often leaves an obstinate perineal fistula; whilst in women with tuberculous bladder it not infrequently produces total incontinence of urine. Opium, sandal oil, sea air, and occasionally washing out the bladder will often work wonders. If these measures fail, there is still the cauterization of the tuberculous deposits under electric light, or the more unsurgical method of wholesale curettage through a suprapubic incision to fall back upon.

THE SIMULATION OF OBSOLETE TUBERCLE AND TUBERCULAR PROSTATITIS.

The lecture just referred to gives some suggestive thoughts on the following subjects:

Obsolete Vesical Tubercle simulating the Contracted Bladder of Concentric Hypertrophy.—It is of importance to remember that vesical tuberculosis obsolesces by burning itself out. The mucous membrane is more or less completely destroyed and sloughs away. An inelastic, stiff-walled little reservoir of the capacity of

3 ounces remains. The patient is free from any pain. His stream is forcible, but thin and of short duration: the urine is clear, but he is worried by the frequency of incapacity, being only able to retain a wineglassful at a time. Every half hour by day and night the urine is passed, and he clamors for some relief from the distressing frequency, the annoyance of the urinal, and the chafing of the abraded, urine-sodden genitals. Similar contraction of the bladder results from other forms of interstitial cystitis, for example, that due to calculus, stricture, perimetritis, etc.

Dangers of Treatment.—The well-known value of dilating, by means of hot water injection, bladders contracted by the concentric hypertrophy of disuse suggests to the practitioner the use of the same method in every case of contracted bladder, but often the result is disastrous. There is no bladder so rigid, so inelastic, so intolerant of distension as the "cured" tuberculous bladder. No muscle plane proves so friable as the stiffened fibro-muscular wall left by the disease in question. If you attempt to dilate such a bladder, expect hæmorrhage or recurrence or subperitoneal rupture in the neighborhood of the uterus. Leave well alone, and modify by drugs the acridity of the urine.

Primary Tuberculous Prostatitis simulating Gonorrhœal Infection of the Onanitic Prostate.—The majority of cases of primary prostatic tuberculosis are recognizable *per rectum* by the discovery that one or both lobes are occupied by one or more hardish nodules, which vary from small shot to a horse bean in size. Moreover, the persistency of the irritability of the bladder, the unrelievable pain in the perineum and glans penis after micturition, the occasional appearance of blood at the end or at the commencement of the stream, the agony of instrumentation, together with the presence of pus and debris in the urine, will be enough to guide you after the rectal examination to a correct solution of the nature of the trouble. Sometimes, however, the deposit is buried in a general swelling of the prostate provoked by the irritation of the tubercle. When this is so, rectal examination—even with a highly-educated finger—is inconclusive, for a prostate of precisely similar shape is encountered after a gonorrhœal attack has been grafted on a prostate enlarged and indurated by early and excessive masturbation. For my own part, I am myself unable to differentiate between these two conditions, and have lately relied upon an injection of a weak solution of tuberculin, or I have withheld my diagnosis and all topical treatment until the subsidence of the general swelling or the implication of the vas or testis has permitted of a certain diagnosis being made.

Dangers of Treatment.—The usual method of treating chronic prostatitis by deep injections sweeps the tubercle into the bladder, and thus one of the natural barriers to the spread of the disease is broken down. The cauterization of the prostatic mucous membrane is often followed by severe reaction in tuberculous cases, and tends to excite abscess in the deeper parts of the prostate—a result which in these cases is fraught with danger; for the prostatic tissue under these circumstances is apt to be completely shelled out by sloughing, and an incurable incontinence is the result. Avoid, therefore, all instrumentation.

Medical Items.

The second annual meeting of the American Electro-therapeutic Association will be held in New York, October, 4, 5 and 6, 1892, at the New York Academy of Medicine, 17 West Forty-third Street.

Theodore Meynert, the distinguished alienist and neurologist, died recently at Vienna, at the age of fifty-nine years.

The late Dr. D. Hayes Agnew left an estate of about $250,000. He bequeaths to the University of Pennsylvania $50,000, his work on surgery, his library and anatomical collections.

By the will of the late Mr. Robert A. Barnes, of St. Louis, the sum of nine hundred thousand dollars will become available for the building and endowment of a new hospital in that city. The management of the fund will rest with the Methodist Episcopal Church South, but the institution, when completed, will be unsectarian in the bestowal of its charities.

Dr. Féré (Gaz. des Hôpitaux) speaks of a patient in whom the epileptic aura takes the form of a cramp similar to that seen in writers. The manifestations become general, so that the attack soon resembles one of ordinary epilepsy. As soon as the attack is passed he is able to write again, which renders the differential diagnosis easy, since this could not be the case in true writers' cramp. The bromides, when given, produced marked improvement.—*Jour. Nervous and Mental Diseases*, June, 1892.

Determination of sugar in diabetic urine by the muscimetric method.—The following is from the *American Druggist:* Prepare a one per cent. solution of grape sugar in healthy urine, pour it in a soup plate: on another pour an equal volume of the diabetic urine: evaporate both to a syrup consistence, then expose both plates in a place where there are flies. After ten or fifteen minutes count the flies on each plate, divide the number on the diabetic urine by the number on the grape sugar solution, which will give the precentage.—*St. Louis Clinique.*

Will asylum-superintendents, and physicians generally, send to the *Medical News* any exact information that they may have as to cases of relapse to drinking-habits, of insanity, suicide, death, etc., of patients that have passed through the so-called cure of the Keely Institutes? Correspondents will please give the names of patients, and as exact data as possible. No public use will be made of individual names, either of patients or of physicians (without consent), but in order to render the statistics useful we ask for the most accurate information possible.—*Med. News*, June, 1892.

A singular case was recently tried before his Honor Judge Jones in the Bolton County court. The plaintiff, Ellis Housley, sued the junior house surgeon at the Bolton Infirmary for £10, the value of one of the arms of his son, who had been injured in an accident at his work. The limb was amputated at the infirmary, and after the operation the plaintiff asked for the arm, but the house surgeon refused to allow him to take it away. A day or two later the boy died, and the father again demanded his son's arm along with the body for burial. It was argued for the plaintiff that he had a right to the limb, whilst for the defendant that there was no cause of action. His Honor said the plaintiff had no property in his son or his son's body and, even if a guardian, was only a guardian during life and not of the dead body, and there was no obligation to bury. After further argument the solicitor for the plaintiff stated that if his Honor was against him on the common law, he could go no further, and there was a verdict for the defendant, with costs.—*Lancet.*

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CONTENTS

ORIGINAL ARTICLES.

A Review of the Literature of Laryngology for the Year. By S. K. Merrick, M. D., Baltimore. 793

A Case of En'erectomy for Obstructive Epithelioma. By J. M. Barton, M. D., Philadelphia. 801

EDITORIAL.

The Future of Maryland. 803

Treatment of Opium Habit. 804

MEDICAL PROGRESS.

Acquired Deaf-Mutism.—Forced Respiration.—Treatment of Diphtheria.—An Obstinate Ulcer. Rectal Injections in Dysentery.—More than a Simple Orgauism.—Galvanism for Dysmenorrhœa. 805

MEDICAL ITEMS. 813

Original Articles.

A REVIEW OF THE LITERATURE OF LARYNGOLOGY FOR THE YEAR.†

BY S. K. MERRICK, M. D.,

Professor of Diseases of the Nose, Throat and Chest, Baltimore Medical College.

This review will only touch upon such matters of the literature of the year as have engaged the attention of laryngologists, and which have an interest more particularly from the standpoint of the general practitioner. I shall take the liberty of introducing illustrative cases drawn from my own practice, when I think the point at issue can be more plainly brought out.

While my aim will be to reflect the best thought and take note of the best work that has been going on during the past year in this department of medicine, I shall run the risk of omitting, possibly, many things which should be brought to your attention, and of saying some which might well be omitted. Trusting, however, to your intelligent discrimination to separate the chaff from the wheat, I shall now address myself to the responsible task before me.

Nothing strikes the reader more forcibly in looking over the literature of laryngology of the year than the intense interest manifested in all parts of the medical world, in the etiology and treatment of the two diseases, viz.: tuberculosis and diphtheria, which still remain the great scourges to mankind, in spite of the splendid discoveries of Loeffler and Koch. The laryngeal forms of these diseases (being the least remediable forms) mark them at once as peculiarly suitable fields

†Read before the Medical and Chirurgical Faculty of Maryland, April 28, 1892.

of investigation and experimentation to the laryngologist. And there is not wanting abundant evidence of his work during the year, in Great Britain, Germany, France and America, not to mention other countries. But it is not the purpose of this paper to do more than mention some of the more interesting features of these investigations and the practical deductions to be drawn from them.

There seems to be a general consensus of opinion among bacteriologists that the Klebs-Loeffler bacillus is the cause of diphtheria. No one who has heard or read Prof. Welsh's address delivered before this society a year ago could fail to accept this statement as proven even at that date. Subsequent investigations have only confirmed the views, which he, in common with other workers in this field, held at that time, there being possibly some rays of light here and there, thrown into dark places since that date. It was then thought that the Loeffler bacillus could be found in every case of true diphtheria, and that the habitat of the bacillus was not in the superficial layers of the false membrane. It is now said to be more frequently found in the deeper layers, and its entire absence, it is said, does not prove conclusively that diphtheria is not present. The profession is under a debt of gratitude to these original investigators for discovering the definite micro-organism which causes the disease. We will be placed under a double debt if they will show us how to *destroy* it in situ. The toxalbumen, which is secreted by this organism, and which is so powerfully toxic, may, and often does, continue to act after the membrane has separated. To neutralize its effects and destroy the bacillus (as the disease is now admitted to be local) are the ends to which rational therapeutics points us. To mention a tithe of the agents which have been recommended would lead us far beyond the limits of this paper as well as of your patience. I shall content myself with mentioning a few, which are more or less novel, and for which excellent results have been claimed.

In an editorial note in the *Journal of Laryngology and Rhinology*, Aug., 1892, the notice of one of these methods begins as follows: "The highly unsatisfactory state of the therapeutics of this terrible destroyer of infantile life is assuredly in nowise better shown than by the amount of literature constantly devoted to the subject, and the number of systems of treatment continually being proposed. Pretty nearly every drug in and out of the Pharmacopœia has had its advocates, and still the sheaves are garnered, and the edge of the sickle has not been turned by drugs and systems." Then follows a description of the method employed by Prof. Seibert, which appeared in the *Archives of Pediatrics*, of June, 1892: "Basing his ideas upon the fact that the pharyngeal manifestations of diphtheria begin as a local process, and that it owes its origin to the entry and penetration into the mucous membrane of the Klebs-Loeffler bacillus; that the pseudo-membrane is not the disease, but the result of the disease, and is a safe guide to the diphtheritic inflammation below it; that the chief treatment should be local, and that the removal of the pseudo-membrane is useless, as the bacilli contained therein are of no further consequence, and the so-called "local" treatment, as carried out generally, does not reach the *active* bacilli in the lower strata of inflamed tissue, and is therefore neither local nor germicidal; that wiping away pseudo-membranes and applying strong antiseptics to the parts is also ineffective, as only tending to cauterize and infect the healthy surrounding mucosa and to rub in the bacilli into deeper parts, and is without germicidal effect;" Seibert has devised instruments for the purpose of bringing comparatively small but strong solutions into *direct* contact with the bacteria which are in activity upon the lower stratum of the mucosa. The antibacillary medium to be used is the officinal and freshly-prepared chlorine water, U. S. P., and with a syringe, the chief feature of which

appears to be that there are five needles instead of one. These five points are pressed firmly to their full length into the pseudo-membrane, so as to reach the inflamed tissue below, and the chlorine water is injected into the part. Thus brought into direct contact with the active bacilli and cocci of diphtheria, these latter are destroyed and "the process comes to a stand-still." After the injection a gargle of one or two grammes of tincture of iodine and ten drops of concentrated carbolic acid, in four ounces of water, is given, a teaspoonful being alternately gargled and swallowed, every fifteen minutes from 6 A. M. to 12 P. M. at night; five drops for gargling, and half a teaspoonful every half hour for swallowing, being given to younger children. Zinc and mercurial ointments are rubbed into the swollen glands and an ice-bag adjusted over the swollen parts of the neck.

Of 35 cases treated by this method, Dr. Seibert claims to have cured 33 with no local paralysis following in any case. This is a good showing, and we expect to hear more of this method in the future and hope the results may justify the conclusions which may be drawn from the foregoing statistics. The galvano-cautery has been used, it is claimed, with success, and the red-hot poker has even been used as a means of destroying the bacilli in situ.

Are any of the foregoing methods applicable to very young children? Peroxide of hydrogen, corrosive sublimate and calomel internally have their advocates. I desist from mentioning others. With the results of intubation in laryngeal diphtheria you are all more or less familiar.

Muralt, at a meeting of Gesellschaft der Aerzte in Zurich, Jan. 31, 1891, reviewed the question of intubation and concludes it is a useful operation. Kronlein believed that tracheotomy is generally better, and Ranke, of Bremen, concludes, after a collective investigation by ten authors, that intubation is inferior to tracheotomy.

Waxham, of Chicago, published "Statistics of Intubation" in *Archives of Pediatrics*, July, 1891, and Richard B. Faulkner, M.D., of Allegheny, Pa., an article in the *Medical News*, of Philadelphia, April 9, 1892, to which I would refer any one especially interested in this subject.

Dr. Moll, at "The Annual Assembly of Belgian Laryngologists" reported 103 cases of stenosis of the larynx of diphtheritic origin. He performed intubation 92 times with 37 cures (42.2 per cent.): of these 37 cases, 32 were cases of infants of tender age.

At a recent meeting of the British Laryngological and Rhinological Association Mr. Mayo Collier related a case of post-diphtheritic paralysis of the palate, following two months after a slight sore throat, not sufficient to call for treatment, causing considerable interest and discussion. I have notes of a case that I wish to relate treated by me in 1887, which has never been reported, and which has a similar history to that above. I should like to have it explained in the light of recent bacteriological investigations, which go to show that the very mild cases of membranous sore throat are due, not to the Loeffler bacillus, but to a pseudo-bacillus much less virulent and dangerous. I was called to see a little girl five years of age who had slight fever and slight sore throat. Some simple gargle was given, with tincture of iron and sulphate of quinine internally. In a few days she was well. Indeed, she never went to bed, and no membrane was seen in her throat at any time and I did not even think of diphtheria in connection with the case. A few days later I was called to see her brother, age three years, who was taken much as she was, except that I found a patch of false membrane on one tonsil. In a few days he got well under the same treatment and the illness was so slight that I never seriously thought of the case as diphtheria. A few weeks

afterwards the first case was brought to my office with paralysis of the soft palate and fluids passing through the nose on deglutition. The diagnosis of diphtheria was now clear. The child recovered under appropriate treatment. But the sequel to these cases is a sad one. This non-membranous sore throat was the beginning of the most virulent local epidemic of diphtheria I have ever seen. Thirteen deaths followed from malignant diphtheria in the immediate neighborhood before a recovery took place.

For the treatment of this dreadful disease I have nothing to suggest, but in dismissing the subject would commend Loeffler's opinion on the same, who believes that a natural therapy can only be found by the study of the effect of different medicaments on the cultures of the diphtheria bacilli. We must look to those who discovered or have studied the organism in laboratories for an unfailing agent to destroy it. In view of the doubt which may exist, even after a microscopic examination of the membrane, attended with failure to find the bacillus, the only safe plan for the practitioner would seem to be to regard as diphtheria all cases of sore throat of a doubtful character, and treat them accordingly.

Laryngeal tuberculosis next claims our attention, but we shall not dwell at such length on this subject, although the literature of the year concerning it is very voluminous.

It was hoped when Koch's tuberculin was introduced that many sufferers from this most fatal disease would be relieved from an almost certain death. With the disappointing results you are all familiar, and were it not for the reports of cases of either improvement or cure of laryngeal phthisis, which are still brought to the attention of the various laryngological societies at nearly every meeting, I should pass this subject by as one which had been already discussed *ad nauseam*.

In an excellent paper read at the meeting of the British Laryngological Association, March 25, 1891, entitled "Bacteriology in Relation to Diseases of the Nose and Throat," Dr. John McIntyre says: "As far as we are concerned, we had as little sympathy with the great wave of enthusiasm which resulted from the announcement of this discovery as we have with the condemnation which it is now receiving in many quarters. Time alone must settle the permanency of the improvements which undoubtedly have taken place in some, though it may be few, of the cases.

Sufficient time has elapsed since then to throw much light on this question of *permanent* cure of laryngeal phthisis and so late a number of the *Journal of Laryngology and Rhinology* as February, 1892, contains at least two cases of cure noted; the first by Lenzmann, the reporter, with tuberculin, the second by enucleation. Out of 40 patients with tuberculosis of the lungs were some patients with laryngeal phthisis; one of them has been cured."

The other case was reported by Heryng. This case was treated by enucleation; and Dr. Fraenkel, in Hamburg, who made a microscopical examination of the specimen, pronounces that this was a case of absolute cure. A number of other cases might be given to prove that a very small per cent. are permanently cured by one method or another; tuberculin, curettement, enucleation, lactic acid, menthol, and possibly cantharidine salts. Temporary improvement occurs in many cases, yet the extreme rarity of permanent cures must be admitted by all candid minds. The results thus far achieved by any method are all far from satisfactory. But the positive proof that some cases of laryngeal phthisis have been permanently cured imposes a new responsibility on the practitioner. Let us acknowledge this additional responsibility in a liberal spirit and help on the good cause of investigation.

The measure of success in any case, with any one of the agents named, will depend in no small degree upon the proper selection of the case. With the dangers of tuberculin you are all familiar, and with the fact that its universal application does far more harm than good.

Personally I have never known a case of undoubted laryngeal tuberculosis to get well under any treatment; but I believe there have been cures by several of the agents above enumerated. Temporary improvement I have often observed without the employment of any of them. Liebreich's method, referred to above as the cantharidine salts method, consists in injecting subcutaneously solutions of definite strength from one to four decigrammes at certain intervals. While many cases of laryngeal tuberculosis have been reported improved and a few cured, the outlook does not seem to be very favorable for the successful use of this drug. Polyak, Hochhalt, Irsay and Navratil all failed to get any permanent improvement with it, and strangury, headache and fever often followed its use.

It is to be hoped that some far more potent agent for the destruction of the Koch bacillus, and far less harmful to the human economy, than any we know of, may in the near future be discovered for the relief of tubercular subjects, 3,000,000 of whom annually fall victims.

Before quitting the subject I wish to advise against the routine practice of many practitioners of spraying the pharynx and larynx of patients with laryngeal tuberculosis with solutions of 4 to 20 per cent. cocaine several times daily. When there are concomitant lung lesions (and this is generally the case) with copious expectoration, the larynx is often covered with a thick dense secretion which adheres too firmly to be removed with the spray, the solution often fails to reach the membrane beneath, while the pharynx and buccal cavity are deluged with the local anæsthetics, producing perversion or extinction of the sense of taste, and sometimes general toxic effects.

The larynx should be cleaned out with an aluminium or copper cotton applicator, until no secretion is seen clinging to any part of it; and the parts brushed by means of the same instrument and a new pledget of cotton, with a suitable solution of cocaine. By this method the larynx is thoroughly freed from the offensive secretion, the taste and appetite are undisturbed and the general comfort of the patient conserved. Within the past year I have treated two patients in this way who had been sprayed several times daily with strong solutions of cocaine, in spite of which they soon became unable to swallow fluids, and were referred to me for treatment by their respective physicians.

The first patient was able to swallow within twelve hours after the first cleaning out of the larynx and application of cocaine.

The second patient, now under treatment, began to swallow in two days without the fluids passing through the nose. Bogroff (*Vratch*, 1891, November 16) says: "Good results were noticed by the author after injecting sublimate solutions, with fuchsine, in cases of difficulty in swallowing, if these difficulties arose in consequence of irritation in the larynx, produced by secretion of the lungs. The act of deglutition moving the larynx doubtless agitates the adherent secretions, and thus they are often the cause of spasmodic closure of the same.

Another reason why this treatment of spraying in every case with cocaine solutions should not be adopted is the fact recently brought to the attention of the profession, that this drug itself is capable, in a certain per cent. of cases, of inducing spasm of the larynx, a very important thing to remember.

Mr. Mayo Collier brought forward a case at the meeting of the British Laryn-

gological and Rhinological Association, March 20, 1891, of "symmetrical growths of the vocal cords." Of this case he says: "On the first examination, the throat was so irritable that it was quite impossible to introduce the forceps even into the mouth, much less into the larynx, and cocaine remained absolutely without effect in diminishing the hyperasthesia. He thought it "vastly inferior to simple gargling with cold water or the use of ice, or, what was still better, training." With regard to cocaine, Lennox Brown expressed himself as follows at the same meeting: "In many patients it proved itself more of an irritant than an anæsthetic;" and mentioned a case in which the first operation having been carried through under cocaine, the patient on the second occasion said he suffered less without it.

I cannot go so far as these observers in my estimate of cocaine; indeed, in proper cases, I regard it as invaluable. Yet in the light of recent observations I am fully convinced that there are some cases in which its use should be interdicted as being harmful from every standpoint.

In support of the position taken by Mayo Collier and Lennox Brown, I beg leave to relate a case of multiple papilloma of the larynx which is very well shown in the drawing which I exhibit.

Some time in the summer of 1888 there came to the N. W. Dispensary a negro man, Perry C., aged 35: occupation hod-carrier. Patient was robust and muscular and said he was perfectly well excepting his hoarseness. Patient had aphonia and on laryngoscopic examination there was found a chronic laryngitis and the neoplasms shown in the drawing. Cords were nearly normal in color and not thickened. No history of syphilis could be elicited, and no subjective or objective evidences of this disease were present. The pharynx was reddened and the membranes somewhat thickened. The voice trouble came on with a severe cold, he said, and my diagnosis was papilloma, result of subacute or chronic laryngitis.

There was much irritability of the throat after several weeks of failure to get the forceps into his larynx. After making four per cent. applications of cocaine, I sent him to the Maryland General Hospital, where, under cocaine and training, I thought after three months I could venture to bring him before the class of medical students at my clinic and do the operation in their presence. After stating to the class the great irritability of patient's throat I used with spray a 20 per cent. sol. of cocaine, and talking about the case for five minutes, I seated myself at the laryngoscope, and found to my chagrin that the irritability of the throat was such as not to tolerate the presence of a mirror, much less a forceps. About six weeks after this I brought my patient again before the class, the throat being trained and cocainized in the interval several times a week. On this occasion when I was ready to operate, I was furnished an old solution of cocaine of both doubtful strength and age, it having turned quite yellow. The druggist had none of the drug left and I would not wait for a new solution to be gotten, but seized the atomizer and sprayed the man's throat, expecting it to have little or no effect. I had never thought of trying to operate without cocaine. Allowing a few minutes for the drug to act, I seated myself and, with a pair of Mackenzie's forceps, was delighted to find I had little trouble in seizing one of the growths and removing it. I reintroduced them and removed a large part of one of those remaining. The blood now began to flow, and obscured the parts so that further effort at removal was deemed inexpedient. A specimen was furnished Dr. Jos. T. Smith, who kindly made a microscopical examination for me, and it was pronounced a papilloma.

The patient's voice was so much improved that he left the hospital a few days

after the operation without leave, and passed from under my observation for a time. The training which this patient was undergoing would doubtless have done much good in overcoming irritability of the throat, but the use of *strong* solutions of cocaine *caused* what *both* were introduced to *prevent*, viz.: spasm.

Driving on the street one day I saw my patient and beckoned him to come to my carriage. His voice was much improved, and being desirous of affecting a thorough cure, I told him to come to my office that night and I would complete the operation. He came, and not attributing my previous success, with the weak and possibly inert solution of cocaine, to its proper cause, I fell into the fatal error of again using 20 per cent. solution of this drug, and the result was a signal failure. What was worse, I used the solution so freely that my patient was made quite ill, and I never got another opportunity to use my skill on him.

This class of cases I do not believe to be numerous, but the evidence to my mind is conclusive, as furnished in this case, that such cases do exist, and that this was one of them. I recall other cases where the failure to get results with cocaine, I am sure, was due to this property of the drug. Apropos to this form of laryngeal neoplasm, I think it worth while to refer to two cases reported by Dr. Garel at a meeting of the French Otological and Rhinological Association, in which there was spontaneous disappearance of papillomata of the larynx after tracheotomy. We opine, however, that most persons suffering from these growths will prefer them to be removed "per vias naturales." With *children* of tender years the advantages of this method are apparent, and it will, no doubt, have a field of usefulness in a limited number of cases.

The treatment of catarrhs of the nose and naso-pharynx has undergone no radical changes during the year of which I am aware. Competent throat specialists, both here in America and in Europe, as a rule, still regard the chief and rational treatment in these common affections, when chronic, as surgical; the spraying, cleansing, etc., coming in, in the majority of the cases, as useful and possibly necessary adjuncts.

In an original article in *Journal of Laryngology and Rhinology*, March, 1891, by Dr. John Sedziak, of Warsaw, entitled "Deviations of the Nasal Septum," he says, "In the last 'decennium' an enormous activity in this direction can especially be remarked," and further, that "American physicians in general have particularly occupied themselves with this condition." Nasal obstructions, such as enchondromata, osteomata, exostoses and simple cartilaginous deflections, and the catarrhal conditions induced by these, may be very well understood by the general practitioner in the large cities of this country, but we seriously doubt if the general practitioner fully appreciates the gravity of the host of ills which are caused by nasal stenosis. America, however, has held her own, if she has not led, in this field of investigation.

The galvano-cautery, saw and cold wire snare and dental engine are probably the most popular agents for the destruction of excess of tissue, whether soft or hard; while menthol, thymol, eucalyptol and some others, in oleaginous solutions, are among the most used for spraying. One very attractive method of treatment—I refer to electrolysis—has been investigated by numerous operators; but I shall quote only one authority, viz.: Draispuil. He investigated at the polyclinic of Dr. Schnitzler, at Vienna, the effects of electrolysis in different diseases of the nose, throat and larynx, and came to the conclusion that it acts very slowly, especially if we have to destroy considerable portions of tissue; where the writer had to destroy small portions of tissue, and especially when the tissue was rich in vessels or fluids, good and quick results were obtained. He found its application in the larynx very difficult, and was unable to keep his instrument in contact with the laryngeal tissues more than one or two minutes, after which

time the patient began to vomit. It must be confessed that this agent has still a limited field of usefulness in the hands of the throat specialists, yet it has been of service in reducing the *size* of fibromata of the nose and naso-pharynx. The diagnosis of antrum disease, and especially growths, can, it is claimed, be rendered easier by transillumination. The patient is put in a dark room and an electric light placed in the mouth; the difference in translucency between the healthy and diseased side is the key to diagnosis. Subglottic tumors of the larynx in patients too young for the successful employment of the laryngoscope have been also diagnosed by transillumination.

Recurring to nasal obstruction, there is one cause, though comparatively infrequent, which must not be entirely overlooked. I refer to rhinoliths. At the May and June meeting, 1891, of Laryngologische Gesellschaft, in Berlin, Herzfeld showed a rhinolith, extracted from a lady thirty years old, who, since her youth, had an obstruction of the left side of the nose.

This specimen which I show the society was removed from the left naris of a negro girl, 12 years old, who had been subject to severe periodical attacks of epistaxis for six months. After trying in vain to avert this troublesome bleeding by the usual means, her physician referred the case to me for treatment. I found some air passing through the obstructed side, but less in volume than what is normal. On illumination and inspection no foreign body could be seen, but the probe soon revealed the presence of a hard substance, located on the floor of the nose, and wedged in tightly between the septum (at the anterior border of the vomer) and the inferior turbinated body. It was removed by means of a blunt hook, leaving a large ulcerating surface, which healed in a few days under appropriate treatment, and there was, of course, no more nose-bleeding.

The cases which I have introduced into my paper are reported as contributions to the literature of the respective diseases and morbid conditions to which they belong.

Mr. President, I feel this review would be incomplete did I not take notice of the great gap that is left in the ranks of the laryngologists by the sudden and untimely death of one of our most distinguished members, Sir Morell Mackenzie. On the morning of February 4th, 1892, the whole civilized world was shocked on seeing the announcement of the death of this great man, for Mackenzie's name and fame are co-extensive with civilization. To prince and to peasant alike was his name familiar.

From the time he won the much coveted Jacksonian prize of the Royal College of Surgeons, in 1863, his name has been the most conspicuous in the literature of laryngology. Indeed, no adequte biographical sketch could be made of Sir Morell Mackenzie that would not contain a history of modern laryngology. Time will not permit me to mention even by title his writings. Suffice it to say that they were so extensive and comprehensive that others in the department were compelled to pay him the sincerest compliment by blindly imitating him or seize the other horn of the dilemma and keep silent. Of one of these appropriators of his drawings Mackenzie speaks somewhat caustically as follows: "The best evidence of the appreciation of a book is no doubt to be found in its sale, but were I to seek for further testimony I should refer to the fact that the only systematic text book on the laryngoscope published in this country is based entirely on my treatise, and to the circumstance that its author has paid me the very flattering, though somewhat unusual compliment, of allowing several of my drawings to appear as his own."

What our own beloved Sims was to gynæcology, England's Mackenzie was to laryngology.

843 N. Eutaw St.

A CASE OF ENTERECTOMY FOR OBSTRUCTIVE EPITHELIOMA.†

BY J. M. BARTON, M. D.

I exhibit a patient on whom I performed an enterectomy for obstructive epithelioma five years ago, and I do so for three reasons: First, as an example of permanent recovery from intestinal cancer; it is now nearly five years since the operation, and she is in perfect health. Secondly, to exhibit the apparatus which she wears on the intestinal fistula. Thirdly, to show the results, and to recommend the wider use of the method employed to reëstablish the intestinal channel, particularly in cases of high obstruction.

I have opened the abdomen of this patient three times. First, on May 2, 1887, by a median incision, for severe recurring attack of obstruction, which had lasted a year. An intussusception with adhesions was found, with a closely contracted ileo-cæcal valve at its apex. The intussusception was reduced, the colon opened, and the valve exposed and dilated. Some months later the symptoms of obstruction returned, and on November 1, 1887, six months after the first operation, I again opened the abdomen, this time by an incision similar to the one we now use for appendicitis, and found an epithelioma at the ileo-cæcal valve, nearly filling the entire caliber of the bowel. I removed three inches of the intestine, including the diseased portion, and immediately introduced Dupuytren's enterotome into the ends of the remaining bowel, viz., one blade into the ileum, and one blade into the cæcum; the two blades were then brought together, and the screw run down firmly, a heavy ligature being then placed around the two ends of the bowel, including the enterotome, to prevent the escape of feces during the subsequent manipulations; after the abdominal wound was closed, this ligature was cut. In eight days the enterotome dropped off, having cut through the two contiguous layers of bowel: it was immediately reapplied to the spur, and three more inches divided, and after it was applied for the third time and had dropped off it had made a total incision of nearly nine inches in length. It was not until I had used a modification of Mr. Michael Banks's method, by a T-shaped arrangement of rubber tubing, that the results were entirely satisfactory. The specimen, which I will pass around, was examined microscopically by Dr. Morris Longstreth, and pronounced to be a cylindrical epithelioma. These two operations were reported in the *Journal of the American Medical Association* for May 5, 1888.

Some months later the patient detected a large gland in the mesentery, and for its removal I opened the abdomen for the third time on June 20, 1888, by a curvilinear incision, about ten inches in length, parallel with the edges of the ribs, and running back into the loin. She recovered as perfectly and as quickly from this as she had from the previous operations, and is now, and has been ever since, in perfect health, and quite able to do a full day's work at the washtub or elsewhere.

The fecal fistula which remains gives her but little annoyance: with the aid of a compress and cork she is able to restrain all leakage, and finds it necessary to cleanse the parts but once a day. Her bowels are open once daily by the natural outlet, and her condition is quite comfortable, so much so that she declines any plastic operation for the closure of the fistula, though I know she is not cowardly, and always regarded an abdominal section as a trifle.

This case is the last in which I used this method for reëstablishing the fecal

†Exhibited May 25, 1892, five years after the operation, before the Philadelphia County Medical Society.

circulation. Since then we have been using bone, catgut, and rubber rings. But rings have had their day; the opening obtained by them is too small for anything except temporary use, it rapidly contracts, and the obstructive symptoms recur. In a case in which I shall have to operate in a few weeks I shall not use rings, but shall adopt the "four-inch" incision of Abbé, and I am so far from feeling certain that the four-inch incision will not contract too much that I regret I did not adopt this method at the primary enterectomy, three weeks ago, even though an anastomosis operation was afterward to be performed.

In most of our enterectomies for chronic obstruction, the patient is frightfully exhausted before we have the opportunity of operating, and the best authorities now agree that the removal of the affected intestine and the establishment of a temporary artificial anus is all that we can hope to do at the primary operation, leaving the reëstablishment of the intestinal circulation to be accomplished at a second operation after the strength of the patient has been restored.

Now, if the obstruction is high up in the intestine and an artificial anus is made, it is quite questionable if, from the intestine above the artificial anus, the patient will ever absorb nourishment enough to gain the necessary strength to have the anastomosis operation performed. But, if Dupuytren's or some similiar clamp was used at the primary operation (its adjustment does not take thirty seconds), within a few days some of the nourishment would pass to the lower intestine, and when the strength has been reëstablished the anastomosis operation could be performed, if desired. The application of the clamp does not prevent the immediate and continuous use of the artificial anus.

CURE OF A STRICTURED ŒSOPHAGUS AFTER GASTROSTOMY.

At a recent meeting (*Lancet*, June 4) of the Clinical Society of London, Mr. Clutton related the particulars of a case of Gastrostomy for Stricture of the Œsophagus at the age of four, in which the normal passage was eventually restored. The patient, a girl, was admitted into the Victoria Hospital for Children, in July, 1889. Seven weeks previously she had swallowed some caustic soda. At the time of her admission she was unable to swallow anything at all, and a bougie was arrested at six inches from the teeth. During August she was fed entirely by nutrient enemata and no bougies were passed, so as to give absolute rest to the œsophagus. In September, although she had materially improved in general, no instrument could be passed through the stricture. On September 13th the œsoghagus was opened in the neck, with the hope of being able to reach the stricture, but the obstruction was found to be within the thorax. After these wounds were closed with suturing, the first stage of gastrostomy was carried out by means of harelip pins. Five days afterwards the stomach was opened and the child fed through the gastric fistula. On January 27th, 1890, a very small whalebone bougie was at last passed through the œsophageal stricture, and, after many months of varying success, a No. 14 œsophageal bougie was eventually passed with ease. During 1891 this large bougie was passed about once a month and the plug removed from the gastric opening. Attempts to close this opening were subsequently made by passing the actual cautery along the sinus, and it was now absolutely closed. She was in perfect health, and came to the hospital once in six weeks to have the bougie (No. 14) passed. No contraction could be felt. The points of interest were: (1) The age of the patient; (2) that after gastrostomy the œsophageal stricture was eventually dilated and the passage restored to its natural function.

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Editorial.

THE FUTURE OF MARYLAND.

To any Marylander who is suffering from acute or chronic pessimism in regard to the future prospects of our State we recommend a perusal of the able work of Mr. Thomas Scharf† which now lies before us on our office table.

Here, in simple and temperate language, we find set forth the natural resources which will some day, under the influence of forces now beginning to operate, place Maryland among the wealthiest and most beautiful countries of the world.

With the mitigation of the curse of hand-to-mouth politics, for which every patriotic citizen earnestly hopes and labors; with the increase of the population in her county districts, and the more careful and intelligent cultivation of the soil which will ensue; with the utilization of her varied mineral treasures, which are as yet almost untouched; and with the leasing of the shallows of the Chesapeake to individuals and to corporations who will develop its untold wealth, but recently made known to the public; a new era of prosperity will soon dawn upon us.

It is time for the Marylander to stop croaking and complaining about the past, and from the present to look hopefully forward to the future. The evils which hinder our progress are remediable.

Corrupt methods in Legislature and City Hall, which hinder useful advances and fill public offices with self-seeking men, unfit for their duties, may be corrected by steady, combined and open resistance on the part of those who believe that what is *right* is *most expedient*. Our agriculturists will after a while learn that it is better to cultivate 50 acres properly and make a living, than to "farm" 500 acres—old fashion—and lose money on it. Orchards and truck gardens will bring wealth from sandy or gravelly hills where formerly sickly cereals wilted in the

†The Natural and Industrial Resources and Advantages of Maryland, by J. Thomas Scharf. A. M. LL.D., Annapolis, Md., C. H. Baughan & Co., State Printers, 1892.

sun or waged unequal warfare with enterprising weeds. From yet unopened quarries will come treasures of marble and stone whose rare beauty and variety are now known only to the mineralogist.

Our bay, where now the dredger roves in barbaric freedom, will be divided into marine gardens planted thick and carefully with oysters of rarest flavor and of great size.

Let us, as citizens and patriots, follow the well-known motto, "Look up, not down; forward, not backward; and *lend a hand.*"

TREATMENT OF OPIUM HABIT.

In the issue for July of the *Denver Medical Times* (which is to be congratulated on its appearance in very handsome garb), Dr. Graeme H. Hammond gives his views in regard to this difficult subject. He holds that such patients can in the majority of instances be permanently cured by intelligent treatment, if they are not afflicted with preëxisting painful and incurable diseases.

The physician must absolutely control the patient. On removal to the room which he is to occupy, he should be stripped and put to bed in night clothes, none of his clothes or belongings of any sort being allowed in the room.

Opium is now given in the form used by the patient—but not by hypodermic—in rapidly diminished doses at first, and afterwards more gradually lessened, the patient being kept ignorant of the amount given. Strychnine should be given with morphia doses, as its bitterness prevents the detection of the diminution of morphia. Laudanum should be given for the same reason in an aromatic mixture, such as guiriptus, which resembles it in color and masks the taste.

Old habitués cannot bear sudden and total withdrawal of the drug, which may result in heart failure and collapse, morphine being a heart tonic. As the opium is diminished, heart tonics must be added to it. One or two granules of glonoin, $\frac{1}{100}$ grains each, should be allowed to dissolve on the tongue whenever the intense craving for morphia is felt. Inhalations of amyl nitrate are also good. Sparteine sulphate $\frac{1}{4}$ to $\frac{1}{2}$ grs., and strophanthus tincture, 10 drops t. i. d., serve the same purpose, replacing the heart-tonic properties of the opium withdrawn. Sulfonal (say 25 grains) is given at bedtime if there is insomnia. Massage is good for the body pains of opium craving. The recumbent posture rests the heart, and hinders collapse.

After the opium has been wholly withdrawn, there is left an undefinable restless craving for the patient knows not what, which will, if not relieved, lead him back to opium. This feeling indicates nervous and muscular debility, and must be removed by tonics and regular systematic exercise—especially upon the bicycle. A careful nourishing diet is of importance throughout the treatment.

The honorary degree of Doctor of Laws was conferred on Dr. J. J. Chisolm at the commencement of the South Carolina College, in Columbia, S. C., June 29th. Dr. Chisolm is a graduate at this college.

Medical Progress.

ACQUIRED DEAF-MUTISM.

The popular notion that the deaf and dumb are always born in that condition is by no means correct. Deafness may be acquired in the early months of life, and if it persists it results in dumbness. I can offer no information as to the relative frequency of congenital and acquired cases of deaf-mutism, but I wish to show that in some instances, certainly, the acquired form may be remedied. Children often become deaf in the early years of life, and there seems to be no reason why the same should not occur in their early months; and in the latter event they will never learn to speak naturally unless the cause of deafness be removed. I have met with one example of the recovery of fair hearing without treatment, in adult life or in adolescence, in a man who had been regarded as a deaf-mute; but he never learned to converse, though he could utter a few short words, and could answer questions if they were so formulated as to allow of monosyllabic responses. This man had not learned "lip-speaking;" he heard ordinary sounds around him, but he always wrote his remarks if they needed to be put into several words. Another patient, a woman, presented a very similar history and condition, but was unable to articulate any intelligible sound; she replied to questions by signs only. She was, however, of somewhat feeble intellect. The case to which I would more particularly call attention is that of a child, F. P——, who was first brought to me in April, 1889, and was then four years old. She was absolutely deaf to all sounds around her, and it was impossible to get any trustworthy indication as to hearing by conduction through the cranial bones. On examination the child was found to have slight otorrhœa, the membranes of the drums were somewhat retracted, there was chronic catarrh of the naso-pharynx, and the tonsils were greatly enlarged. I removed both tonsils, treated the meatuses and naso-pharynx by ordinary means, and inflated the tympana by Politzer's method. In a few days after treatment began the child gave clear indications of hearing, being startled by loud noises, and was evidently pleased with the sound of church bells, etc. She would also answer a knock at the door, and imitated the "clucking" of poultry. For many weeks, however, she made no attempt to speak, and it was difficult for her parents and sister to overcome their constant habit of communicating with her by signs, for which she was extremely watchful. One of the earliest words she learnt was her own name. In about six months she was sent to school with her sister, where she learnt much more quickly, especially from her school-fellows. She has had several relapses of deafness due to cold during the last three years, but has been promptly relieved by inflation. Her mother has latterly supplied me with a list of over sixty words she pronounces plainly, one of the longest being "grandmother," and another (one of the most difficult, perhaps), "Irish." The list also contains some sentences, such as—"Wait a minute." "I'll tell father," etc. She pronounces all the letters of the alphabet clearly except G, K, N, Q, R, S, and Z, which are less distinctly articulated separately, though words containing those letters are fairly well spoken. She is not quick at figures, but names them perfectly up to seven, and less plainly up to twelve. Before her meals she says "grace," consisting of eleven words exclusive of "amen," which she calls "apen." She also repeats a prayer of nineteen different words, which are well articulated, though in a childlike fashion.

Another case of acquired (as I believe) deaf-mutism was that of a child two years old, who was brought to me for treatment about seven years ago. This

child had never given evidence of possessing a trace of hearing. Her drums were retracted, but she had no perceptible catarrh of the external meatuses. I tried inflation, and at the first attempt succeeded in filling the left tympanum with air, but not the right. After two or three visits the child noticed sounds —e. g., she looked round sharply when I entered the room, though her back was towards the door. The first sound this patient gave evidence of hearing was the loud clacking noise of a metronome which I set in motion behind her back. The child was under observation for only about three months, as her parents, being very poor, had to leave the neighborhood to obtain work; but before going away she had learned to recognize her own name, and responded readily when it was uttered. Up to the time of my losing sight of the case I had never been able to inflate the right drum, but probably should have done so later on, especially if I had used the tympanic catheter. It was very noticeable that on the occurrence of any sudden sound the child invariably turned towards the left, the hearing side. The only other case of deaf-mutism that has been brought to me for treatment was certainly congenital, and curative treatment was impracticable.

Twenty years ago a French surgeon, whose name I forget, suggested that deaf-mutism might be due to Eustachian obstruction leading to retraction of the membrana tympani, and consequent pressure upon or stretching of the chorda tympani, and that the injury to this nerve was the cause of dumbness, from which, perhaps, one may infer that he regarded the chorda tympani as a motor nerve of the tongue, or as being in some way concerned in the production of articulate speech, whereas it is a secretory nerve as to the submaxillary and sublingual glands and sensory as to the tongue. Any cause of total deafness in an infant would prevent speech, and therefore in all cases of deaf-mutism in children a removable source of deafness should be carefully sought and, if found, suitably treated. In connection with this subject I will call particular attention to the use of the tympanic catheter, by means of which the drum may sometimes be successfully inflated when all other means have failed. I have also used it with excellent results to wash out an accumulation of mucus from the tympanic cavity, employing for that purpose a warm solution of pure carbonate of soda, four grains to the ounce.—Dr. Miller, in *Lancet*, June 4th.

FORCED RESPIRATION.

At the meeting of the *American Medical Association* (reported in its *Journal*, June, 18th), Dr. George E. Fell, of Buffalo, read a paper on "Additional Evidences of the Value of Enforced Respiration (Fell Method) in Opium-narcosis." He stated that it was now five years since he first saved a life by systematically respiring for a human being by forced respiration, when the methods in vogue at that time were inadequate to accomplish similar results. Since that time, nineteen human lives have been saved by the method, although it has not been generally utilized by the medical profession. Dr. Fell deprecated the statement that any "unskilled person" could perform forced respiration with success, and related an instance in which intelligent physicians, who were not specially acquainted with his apparatus, were unable to use it without instructions. He also stated that the use of the apparatus could be taught to the crews of life-saving stations or to crews on board ships, so that, after proper instruction, it might be utilized in the saving of many lives that would otherwise be lost by drowning. He also refuted the statement as to the similarity of the method first used by him to that used in the laboratories in operations upon animals, and called attention to the fact that there were nine marked points of difference of practical import between the appa-

ratus devised by him for forced respiration upon man and that used upon dogs in vivisection experimentation.

Dr. Fell reported the twentieth case saved, in which a young woman had been rescued by forced respiration after taking twenty grains of morphine; Case 21, in which an old woman died after having taken an excessive dose of gum opium, although forced respiration was kept up for some thirteen or fourteen hours; Case 22, in which a woman had taken forty-four quarter-grain tablets of morphine dissolved in a glass of water, and whose life was saved after some four hours' work by forced respiration; Case 23, in which three ounces of laudanum had been taken by a prisoner with some sweet spirits of niter, life being saved after four hours' forced respiration and the removal of about eight ounces of blood to relieve the intense cerebral congestion that existed; Case 25, in which a gentleman who had been given up by the surgeons at the Fitch Hospital, Buffalo, and who was in a very precarious condition, was saved by the application of forced respiration for about four hours. These cases thus saved, it was claimed, could not have been saved by any other method than the systematic and regular introduction of air into the lungs by forced respiration.

Dr. Fell expressed a desire that reports of cases of forced respiration be sent to him at Buffalo, N. Y., as he desired to make a full report of results at the next meeting in Milwaukee.

The apparatus consists of a double bellows, which keeps up a steady current of air—three or four movements are sufficient for inspiration, and three for expiration. To the bellows is attached rubber tubing. The air is forced into the lungs through a mask, and escapes by a valve connected with the tube.

TREATMENT OF DIPHTHERIA.

From an interesting article on this subject by Dr. E. Fletcher Ingals, of Chicago (*Med. and Surg. Reporter*, July 2), we extract the following:

In the beginning of the attack, ice taken freely into the mouth tends to relieve thirst and reduce congestion and apparently markedly to limit the progress of the disease. Of even more importance has seemed to me the application externally of ice bags or the ice water coil of metallic or rubber pipe applied to the throat. When ice bags are used, they should be narrow and long and should be about half filled with pieces of ice about the size of filberts; the bag may then be folded in a handkerchief and tied so that it will extend up to the ears on both sides. The ice will need to be changed about every hour. Occasionally patients complain of pain when cold is employed and in these, very hot applications will be found to answer a better purpose, but whether hot or cold be used, it must be continuous; otherwise more harm than good will result.

As soon as the membrane begins to separate, hot applications appear to be more useful than cold. The disease usually causes dangerous prostration, therefore the patient should be well nourished from the beginning. Liquid diet in the form of beef tea, broth, or better yet, milk, should be given at regular intervals and in large quantities; about half a pint or its equivalent being used as often as every third hour. Alcoholic stimulants are recommended early by many practitioners, but to me they seem unnecessary and undesirable until the stage of depression supervenes. Acting on the principle that bacteria cannot live in acid solutions, some physicians recommend the free use of acidulated drinks or gargles, and this possibly explains the reputation recently attained among the laity, by pineapple juice, as a cure for diphtheria. Many substances have been used with the hope of removing false membrane; the simplest of these is steam, which may be impregnated with the time-honored lime water and ap-

plied by the croup tent or any suitable atomizer, but it is extremely doubtful whether lime in any form is ever applied in sufficient quantity to appreciably affect the pseudo-membrane.

Lactic acid is one of the most powerful solvents for pseudo-membrane. It has been highly recommended in about 15 per cent. solution to be frequently employed as a gargle or spray; and in full strength to be carefully applied by the physician twice daily to the false membrane. Tripsin, resorcin and papain have all been used for their solvent effects upon the membrane, but they seem to have little if any influence upon the progress of the disease. Tannic acid and alum are used to astringe the false membrane, and insufflations of sulphur have become extremely popular with the laity, but none of these seem to have much effect upon the disease. Solutions of mercury-bichloride, 1 to 1000, or weaker: of carbolic acid, 1 to 3 per cent.; potassium permanganate, 1 per cent.; liquid sodæ chlorinatæ, 5 per cent.; chloral, about 30 per cent.; or of sulphurous acid, 5 to 10 per cent., have all been highly recommended, from time to time, as gargles or sprays to destroy the poisonous germs in the throat. Peroxide of hydrogen is also used for the same purpose, either diluted with an equal part of water, or in full strength as obtained from the pharmacist. Tincture of myrrh, strong alcohol, and tincture of the chloride of iron have also been recommended, and occasionally tincture of iodine or a strong solution of nitrate of silver are used. I believe that strong applications often do more harm than good, and any remedy which causes the patient pain for more than five minutes is likely to be injurious. Tincture of iron has seemed to me one of the best remedies for local use, as it has also appeared for internal administration. Recently I have adopted as a local application, either by means of spray or gargle, a saturated solution of boric acid in cinnamon water. The researches of Roux and Yersin in 1889 demonstrated that the toxicity of cultures of the diphtheritic bacillus are greatly diminished by the addition of carbolic acid, borax or boric acid, and the experiments of Dr. G. V. Black, reported in the *Dental Review* for February and March, 1889, have shown that the oil of cinnamon, 1 to 2000, is a most efficient germicide; therefore, a combination of these two appears especially suited to the destruction of the diptheritic bacillus. This application is neither unpleasant, painful nor dangerous, and from my clinical observation, it appears very effective. My common practice in diphtheria is to give tincture of iron in large doses, about one minim for each year of the child's age, combined with an equal quantity of glycerine and enough syrup of tolu to make one drachm. This dose is administered every hour in serious cases, or once in two hours where the symptoms are less severe. The patient is first given three or four swallows of water, so that the medicine will not prove irritating to the stomach, then the medicine is administered in as concentrated a form as can be taken without causing pain; the patient is directed to hold it in the throat as long as possible, thus obtaining the effect of a gargle, and it is swallowed. Usually as much as ten minims to the drachm will not cause pain in the early stages of the disease, but later on it may be necessary to dilute the dose with water. The gargle or spray should also be used every hour. Thus, one or the other would be administered every half hour excepting during the night, when it is often necessary to allow the patient to sleep. However, when the disease is progressing it is sometimes unsafe to allow the patient to go more than half an hour without receiving either the gargle or the solution of iron. But I would strongly deprecate awakening the patient more often than is necessary for this purpose, and as soon as the membrane ceases to spread, I would allow the child to sleep one or two hours rather

than disturb it to give the medicine. Quinine in moderately large doses may also be given judiciously, and as the stage of depression comes on, alcoholics should be used freely, it making little difference in the progress of the disease whether they be in the form of wine, whiskey or brandy. Children will often take much more rapidly than any of these a mixture of equal parts of alcohol and syrup of tolu which is practically of the same strength as good whiskey. When the heart fails, no remedy is of so much value as some of the preparations of nux vomica. The tincture of nux vomica although liable to variation in strength has seemed to me to act more favorably than strychnine.

AN OBSTINATE ULCER.

At a recent meeting of the New York Academy of Medicine, Dr. Mary Putnam Jacobi reported a case of persistent ulcer in a girl of four years. Upon admission to the hospital there was an immense ulcer on the right thigh covering its entire anterior and external surfaces from the trochanter to the knee.

This had originated seventeen weeks before from a burn caused by matches which had taken fire in the child's pocket. It was extensive at first, but had steadily increased in size, except in the lower portion, where some reparative process had taken place. Owing to the irritability of the child it had been neglected, and on admission was covered with a thick grayish slough. There was considerable fever, the temperature ranging from 102° to 103°.

Irrigation with a saturated solution of boracic acid and the use of zinc ointment, and a powder of salicylic and boracic acids, was followed by disappearance of the fever, the surface of the ulcer assuming a better character. A number of skin grafts were made, four of which were successful. Sponge grafts were applied unsuccessfully. After four weeks' treatment the ulcer measured 4½ inches by 3½ inches.

Although the grafts grew to be an inch in diameter, the ulcer steadily increased in size until it became 6½ inches long. At the same time it assumed a grayish look, the entire appearance being that of a syphilitic ulcer. Under a dressing of mercurial ointment it again became healthy. Iodide of potash was given internally and for a time apparently with the best results. Improvement then ceased and the ulcer again assumed an unhealthy look. Bichloride of mercury was then added to the treatment (two and one-half months after the date of admission), and from that time improvement continued without interruption and the ulcer had closed in six weeks, eight months from the date of injury.

The child showed no evidence whatever of syphilis, but there was no permanent improvement until anti-syphilitic treatment was instituted. The series of relapses was only arrested when the bichloride was added to the iodide of potash and iodide of iron.

It was suggested that this did not necessarily mean that the ulcer was syphilitic in character, for treatment by iodide failed. It is quite possible that the mercury administered with iron acted as a tonic. The obstinancy of the ulceration might be due to the fact that the original ulcer was caused by matches—burns by phosphorus being noted for their obstinate character.—*N. O. Med. and Surg. Jour.*

RECTAL INJECTIONS IN DYSENTERY.

From an excellent article by Dr. Rosenau, in the *New Orleans Med. & Surg. Journal*, June, 1892, we clip some extracts:

It is important to note that much of the success of treatment depends upon the care and thoroughness with which the method is carried out. This was well

illustrated in a case of sub-acute amœbic dysentery in the wards of the Marine Hospital at New Orleans last January. Injections of one pint of a 10 per cent. solution of peroxide of hydrogen were given through an ordinary hand-bulb syringe once daily. This was continued almost a month. Improvement in all the symptoms followed, but no decided impression was made on the case until large injections were administered, high up, thoroughly flushing out the lower bowel:

After several trials, I have settled upon the following plan of procedure. No claim of originality is made:

The patient lies on his left side, thighs flexed, hips elevated. An ordinary soft rubber catheter is passed its full length into the rectum. The fluid is delivered from a fountain syringe, held from two to four feet above the body of the patient. The finger on the delivering tube acts as a governor to the amount of fluid which is allowed to flow. The lowering or raising of the reservoir determines the amount of pressure.

If the fluid is injected slowly, no pain is caused—except the feeling of weight and tension in the abdomen. Sometimes patients complain of colicky pains about the umbilicus, which pass away after a few moment's interruption of the flow.

If there is much tenderness about the anus and rectum, a cocaine suppository may be given ten minutes before the introduction of the rectal tube.

The amount which different patients are able to retain varies considerably. Adults usually hold four or five pints without difficulty. In some severe cases, where the patient's strength is exhausted and the parts are relaxed, the injection will run out alongside of the rectal tube at the same time that it is being forced in. In such cases I have used the longest rectal tube and continued the injection until the return flow is as clear as the fluid injected.

The relief afforded is prompt and decided, lasting from two to fourteen hours after the enema, the time lengthening as the case progresses favorably.

The solutions which have proven useful in my hands are the following:

Sterile water is efficient, especially in the milder cases. It is best given warm, about 38° or 40° C. If in addition a more stimulating and astringent action is looked for, the water may be given cool or iced.

As a cleanser and antiseptic, peroxide of hydrogen has advantages not possessed by other articles of its class. It is not poisonous, seems not to irritate, dissolves pus and secretions and has antiseptic properties. It has given good results in from 10 to 25 per cent. solutions.

Salicylate of soda, 2 to 4 per cent,, has given satisfaction.

When a decided astringent is wanted in cases of large and repeating hæmorrhage, alum in from 2 to 4 per cent. solutions has been found to act promptly.

The results in some cases of chronic dysentery are most gratifying. The following is an eloquent witness of what may be accomplished in long-standing cases which have shown themselves proof against medication by the mouth.

In this connection, it is well to observe that "thickening of the mucous and sub-mucous coat in chronic dysentery is due partly to infiltration with new cells and partly to new formation of connective tissue. There is, however, less tendency to the development of new fibrillated connective tissue in chronic dysentery than in the chronic inflammation of most mucous membranes; hence, complete recovery is possible after long duration of the disease."

It is remarkable how long a time these chronic discharges may continue and be compatible with working health.

It is proper to state that much of the success of the treatment in these chronic cases depends on the absolute rest in bed and the careful regimen which is insisted upon.

That injections alone will not always cure was demonstrated in the case of a negro steamboatman who was allowed to be up and about during the treatment. A cure was not effected until the rest treatment was combined with the local applications.

An exclusive milk diet is preferred; the milk is peptonized when it is considered necessary. If there is exhaustion or much weakness a generous diet must be allowed. The hygienic surroundings should be the best obtainable.

In the grave or gangrenous form of the disease, injections are only palliative in their effect, and great care must be exercised lest the thinned bowel wall be ruptured.

The dysenteries of moderate intensity are the last class of cases to be considered. Here the results are uniformly good, as observed in the sporadic cases common to this country. The injections cause an almost immediate cessation of straining and blood in the dejecta. The evacuations remain fluid for a few days, when they resume their normal consistence and appearance, and complete and rapid restoration to health ensues.

But satisfactory as the method is, too much enthusiasm must not be displayed in vaunting the results in this class of cases, for as Flint has pointed out, sporadic dysentery of moderate intensity has an intrinsic tendency to recovery, is self-limiting, and ends spontaneously; but judicious measures may relieve the distressing symptoms and abridge the duration of the disease. Injections do all this.

One case of subacute amœbic dysentery under treatment a few weeks last February showed that injections—as might be supposed—do not confer immunity against subsequent attacks. This patient had a return of all symptoms within a month after leaving hospital, apparently cured. In how far the treatment prevents complications and sequelæ can not be concluded from a limited number of cases, although all the cases under my care have been peculiarly free from complications.

The experimental researches of Veronine show that rectal douches are of service as anti-phlogistics, sedatives and excitants.

He finds that injections of cool or cold water produce an increase in tactile sensibility, muscular force, a lowering of body temperature and lessening of arterial pressure, with a modification of pulse tracing. This is experimental proof of the clinical observation of the systemic as well as the local action of injections.

MORE THAN A SIMPLE ORGANISM.

In an address upon "Psychology in Medicine" before the Medical Society of McGill College, Dr. Murray (*Montreal Med. Jour.*, June, 1892) remarked:

There is one interest which the subject creates, and which ought to be of peculiar value to the student of medical science and art. For the psychological relations of his professional work raise it to a position among the noblest occupations in which the energy of man can be expended. A true physiological psychology forces us to a peculiar conception of the human organism. The idea of mere organization is found to be inadequate to explain the nature of man. The structure of the mere animal, like that of the plant, may be sufficiently described in terms of organization; in other words, the structure is one in which the parts are essentially organs—that is, instruments subservient to the uses of the

whole. But man is something more than a simple organism: in him, while the different bodily organs are adapted to the purposes of the whole organism which they form, that organism is itself reduced to the position of a mere organ—an instrument fitted for carrying out the purposes of a mind. Probably when anatomy and physiology have attained a completeness which they are far from claiming as yet, they may be able to show that every tissue of the human body is differentiated in a peculiar way from the corresponding tissues of other animals by the fact that it has to subserve the uses, not of a purely animal existence, but of human intelligence. And thus the profession of the medical practitioner is invested with an aspiring sacredness, when it is viewed as seeking to preserve, in the highest state of efficiency, that marvellous instrumentality which has been provided by the Maker of all for working out the vocation of intelligent moral beings.

GALVANISM FOR DYSMENORRHŒA.

At a recent meeting of the Montreal Medico-Chirurgical Society (*Montreal Medical Journal*, June, 1892), Dr. Lapthorn Smith read a paper upon the above subject, reporting nine successful cases. Describing this method, he recently said:

The treatment by negative galvanism requires none but the mildest currents which can barely be felt, but which cause no pain. This is very different from its use in arresting the growth of fibroids, where the result is very much in proportion to the strength of the current and where galvanic punctures are employed by many. On the contrary, this treatment is actually less painful than the mere passing of the sound, as will appear from the following brief description of the method which I employ. After a careful bimanual examination for the purpose of excluding pregnancy and of ascertaining the position and condition of the pelvic organs, the vagina is disinfected by a douche if this has not already been done at the patient's home. An ordinary Simpson's uterine sound of large size is then bent to the ascertained curve of the uterine canal, passed through the flame of the spirit lamp, cooled and insulated with a clean piece of rubber tubing to within two and a half inches of its extremity, or less if we have reason to think that the uterus is undeveloped. In the handle of the sound a hole has been bored just large enough to hold the tip of the conducting cord from the negative pole or last zinc of the battery. The sound is then guided into the os uteri on the tip of the finger until it meets with some obstruction, when a current of strength of ten milliamperes is turned on. In a minute or two the obstruction will seem to melt away and the sound will glide into the cavity of the uterus. The current is now gradually raised until the patient says she can feel it in the uterus, generally between twenty and fifty milliamperes, being at once lowered on the slightest complaint of pain. At the end of five minutes the current is gradually turned off again, when the sound will be found to drop out of its own accord almost, and very much easier than it entered. This may complete the seance, or as an adjuvant and safeguard, a boro-glyceride tampon may be inserted. The patient may return home on foot and resume her duties forthwith, as such mild applications do not require any precautions in the way of resting, etc. The positive pole of the battery is attached to the ordinary clay abdominal electrode.

The first annual meeting of the Association of Medical Officers of the Militia of Canada was held at the Canadian Military Institute, Toronto, on June 2 and 3. Dr. F. W. Strange, I. S. C., President, in the chair.

Medical Items.

The latest monograph on the appendix vermiformis treats of it as an intestinal tonsil.

For acne in debilitated persons fluid extract hydrastis in moderately large doses is highly recommended.

The Mississippi Valley Medical Association will hold its eighteenth annual session at Cincinnati, October 12, 13 and 14, 1892.

It is said to be a popular belief in England that a man who has had typhoid fever in his youth is incapable of begetting children. Why he should be sterile is not explained.—*Medical Record.*

Eucalyptus honey, made by bees feeding upon eucalyptus flowers, is the latest remedy advocated for the treatment of pulmonary phthisis. It is said to possess the same antiseptic properties as the medicinal preparations of eucalyptus.

Dr. Lewis A. Balch, the Secretary of the State Board of Health, estimates that 10,000 deaths in the State of New York were chargeable to influenza and its sequelæ in the winter quarter of 1892. The local diseases appear to bear the brunt of a largely increased mortality, but influenza is, probably, the genuine cause.

The *Boston Medical and Surgical Journal* says that M. de Haudray, following the method of Prof. Garnier's studies of the Simian languague, has carried his phonograph into the hen coop. He places it in one hen-house where the "family" are at home, and when the receiver has been cackled into for half an hour it is taken away, and made to repeat all the gossip in a neighboring hen-coop. The results of the experiments are said to be marvellous, and the Academie des Sciences is awaiting a lecture on the subject with the greatest interest.

The Annual Session of the Southern Surgical and Gynæcological Association will be held in Louisville, on November 8, 9 and 10. Those proposing to assist in making the meeting a success by the contribution of papers should promptly notify the Secretary, Dr. W. E. B. Davis, of Rome, Ga., of the titles at their earliest convenience. To those desiring to nominate candidates for membership, blanks will be furnished on application. Dr. J. McF. Gaston, of Atlanta, Ga., is President, and is actively at work to make this session as great a success as any of its predecessors.

The profession of West Virginia is evidently not unmindful of the interests of medical ethics. We have before us a clipping from the Charleston, W. Va., *Daily Gazette*, with an eulogistic description of an operation performed by a well-known specialist, with the comment of the sender that "this occurs with a certain medical gentleman about twice a week." We sympathize with our correspondent in his dislike for silent encouragement by physicians of over-enthusiastic newspaper reporters. It is done by some prominent specialists in Baltimore, but excites the dislike and condemnation of our best doctors.

The Second Semi-Annual Meeting of the Eighth Annual Session of the Medical Examining Board of Virginia will be held at Allegheny Springs, Montgomery

Co., Va., at 7 P. M., Tuesday, September 13th, 1892. Examinations of Applicants for license to practice medicine or surgery in Virginia will begin promptly at 9 A. M., Wednesday, September 14; so that it is important that candidates should arrange to arrive at the Springs during the day or night of September 13. Arrangements have been made for the per diem board charge of only $1.50 for each candidate for examination during the week of the examinations. As several matters of great importance to the Medical Examining Board will be considered during the meeting of Tuesday night, September 13, it is specially requested that each member of the Board will attend punctually.

Dr. L. Y. Grubbs, of Topeka, was called by the court to make an examination of a case in a criminal suit and testify in the case. The doctor asked the court to excuse him because of urgent professional engagements. The court refused the request. The doctor then demanded an expert fee, saying that his time and professional knowledge was his capital. The court refused to comply with the demand. The doctor then said: "I have never examined or seen the case, and know nothing about it, and I now demand an expert fee in advance for rendering this service—for obtaining information for the court which requires my time and professional knowledge." The court then ruled that the doctor could not be compelled to render such service without being paid in advance on his demand. There was no money put up, and the doctor was excused. —*Kansas Medical Journal.*

The Tri-State Medical Society of Alabama, Georgia and Tennessee will hold its Fourth Annual Session in Chattanooga, Tenn., October 25th, 26th and 27th, 1892. The membership is not strictly limited to the profession from the States named in the title of the Society, but men of eminence from other States may be elected. Under the vigorous management of its present corps of officers, it is needless to assure our readers that the coming session will be a great success. The mention of the names of Dr. W. E. B. Davis, of Rome, Ga., as President; Drs. D. H. Howell, J. C. Shepard and J. P. Stewart, as Vice-Presidents; Dr. Frank Trester Smith, of Chattanooga, as Secretary; Dr. W. L. Gahagan, of Chattanooga, Tenn., as Recorder, etc., give sureties of active work and successful results. Papers for the session are already promised by the President, by Drs. I. N. Love, of St. Louis; J. W. Cowan, of Tullahoma, Tenn.; E. B. Ward, of Selma, Ala.; J. M. Head, of Zebulon, Ga.; John L. Howell and J. N. Masters, of Knoxville; and C. S. Briggs and Richard Douglas, of Nashville.

"The great majority of our subscribers will cheerfully join in expressing a high appreciation of the honor done by the American Medical Association, during its recent session in Detroit, to the Southern States, and to its most distinguished surgeon, in electing Dr. Hunter McGuire, of Richmond, Va., as its President for the current annual term. The honor is the more appreciated because it was unsought, and because as soon as his name was suggested by admirers in other States, there was not a voice of opposition; on the contrary, even in the session of the Nominating Committee, his nomination was cordially unanimous. Since entering the profession just before the war, Dr. McGuire has been the continuous recipient of well deserved honors. As Medical Director of "Stonewall" Jackson's Confederate Army Corps, he gained national reputation because of his able services."

We heartily join in this expression by a southern exchange of our appreciation of the honor done to the South in the person of this eminent representative of southern surgical progress.

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CONTENTS

ORIGINAL ARTICLES.

Report of a Case of Laryngectomy. By J. Solis-Cohen, M. D., Philadelphia. . . . 815

Electricity to Facilitate the Introduction of the Eustachian Catheter. By A. K. Bond, M. D. 819

Report of the Twenty-First Meeting of the German Surgical Association. Berlin, 1892. Reported by Dr. Julius Friedenwald. . . 820

EDITORIAL.

The New York City Board of Health. . . 824

The Medical Law as it Concerns Doctors Now Practising. 825

REVIEWS, BOOKS AND PAMPHLETS. . . . 826

MEDICAL PROGRESS.

What Microscope Shall I Get?—A Caution to Prescribers.—Arterio-Sclerosis.—The German Professor on Hypnotism.—Resection of the Optico Ciliary Nerves.—Prevention of Uric Acid Gravel.—Relations Between Cancer and Chronic Inflammation of the Breast.—Medicine in Japan.—Influenza and Pregnancy.—General Tuberculosis; Death from Acute Pneumonia.—The Therapy of Eclampsia.—Some Thought Stimulants. . . . 827

THERAPEUTIC RECOMMENDATIONS. . . . 836

MEDICAL ITEMS. 836

Original Articles.

REPORT OF A CASE OF LARYNGECTOMY.*

BY J. SOLIS-COHEN, M. D.

Nineteen years ago the patient, a teamster, then twenty-five years of age, found that he was having some hoarseness of voice, which soon became associated with dyspnœa. The dyspnœa increased in the course of three years to such an extent that he could hardly breathe. He then came under the care of Dr. Lefferts, of New York, who found a large papilloma in the larynx, which growth he removed piecemeal by intra-laryngeal procedures. Dr. Lefferts reported the case in 1876, in the *New York Medical Record*, and I pass around a copy of that journal showing a picture of the growth at that time. For ten years the man remained in continuous comfort. Then recurrence of his former troubles ensued, and he had more or less difficulty for several years, and underwent various treatments. About a year or so ago he began to be much worse, and in January he applied for relief at the dispensary of the Jefferson Medical College. At that time he was suffering with great dyspnœa, and a good deal of pain, cough, difficulty of expectoration, and difficulty in swallowing. The picture of his larynx was almost exactly a reproduction of the picture that I have passed around, and which was taken in 1876—that is, sixteen years ago, with this exception; that the growth, which occupied a large portion of the left side of the larynx, almost occluding it, was white instead of red, and had not

*Exhibited May 25, 1892, before the Philadelphia County Medical Society.

that characteristic papillomatous appearance. The growth had penetrated the larynx exteriorly and projected externally in a mass larger than an almond.

The history of this case led me to believe it to be a redevelopment of papilloma *in situ*, and not to recurrence. The dyspnœa was very great, and I made an appointment to perform tracheotomy promptly; but being suddenly attacked with influenza, W. S. Forbes performed the operation for me at his own clinic, and inserted a tube. This precautionary tracheotomy was performed because I did not consider it safe to attempt a removal of the growth with forceps until we had provided a safety-valve below by means of the tube. Three or four weeks later I attempted to remove the growth by intra-laryngeal procedures. It was easy to catch hold of it with large forceps, and I removed a curious-looking structure which looked more than an inch in length and one-third of an inch in width, much like a piece of codfish-skin. After examining it I came to the conclusion that the forceps had grasped the tumor, but, unable to remove it, had peeled off the thickened epithelium. This was given to a microscopist to examine, and was subsequently reported to be a sarcoma. Finding we could not remove the growth with forceps, we took the patient before the class, where, with the assistance of Dr. Forbes, I excised the external growth and then split the larynx and removed every portion of the internal growth, afterwards scraping the parts thoroughly. The masses removed were subsequently reported as sarcoma. The case did well for four weeks, when recurrence took place, and in less than two weeks the growth became almost as large as at the time of the original operation. It grew more and more rapidly, and again protruded through the necrosed thyroid cartilages.

After explaining to the patient the dangers connected with a radical procedure for extirpation, and after consultation with the surgical members of the Faculty, I decided to excise the larynx. This operation was performed on Friday, April 1st, with the assistance of Professor Keen, and of Dr. O. Horwitz, chief of the surgical clinic.

The day before the operation I had the opportunity, through the courtesy of Dr. Forbes, to perform the operation on an uninjected subject. Dr. Forbes at that time made a suggestion which was carried out in the operation, and the excellent result of which you will see presently. The suggestion was, that after the larynx was removed the anterior portion of the trachea should be split longitudinally for two or three rings, and that the lips so formed should be stitched to the skin anteriorly, so as to present forward and keep the trachea in a favorable position.

There was a good deal of difficulty in the operation owing to the cicatricial tissues and other changes of structure and relations of parts which had resulted from the previous operations. I was, therefore, unable to tie the laryngeal arteries before the extirpation, as I had proposed to do, but Drs. Keen and Horwitz looked after the bleeding while I went ahead with the excision. The incision was made everywhere through healthy structure. The diseased skin and enclosed morbid mass were circumscribed by elliptical incisions in sound skin joining a vertical incision from the hyoid bone above and region of the tracheal canula below; and then a transverse incision was made at the level of the hyoid bone so as to make a T-shaped incision and two lateral flaps. The incision was carried down to the periosteum, and the soft parts were then separated with Allis's dry dissector, which answered admirably. During this time anæsthesia was carried on by chloroform through the tube by means of a funnel and an India-rubber tube. When the larynx had been separated from the soft tissues,

and I could get my fingers around it, I removed the ordinary canula and inserted a tampon canula, to prevent, as much as possible, any entrance of blood into the air-passages. For this purpose I used the von Trendelenburg canula but not the Trendelenburg system. Trendelenburg uses a rubber bag inflated with air. Air or water-bags are very often opened by puncture during the operation. An hour or two before the operation I moistened a piece of ordinary surgical sponge and secured it around the canula, and over this tied a bulbous India-rubber tube. I have here the canula undisturbed; and although fifty-six days have elapsed since it was prepared, you see that the tampon is still perfect, and sufficiently pliable for immediate use.

The patient's head was lowered as soon as this canula was introduced, and anæsthesia was subsequently kept up through the tampon canula, which leaked a little despite all efforts to prevent it. The epiglottis being healthy, I made an incision through the hyo-epiglottic membrane and cut the epiglottis square off. The larynx was then tilted forward. Knowing that there has been difficulty in nourishing patients after this operation, I determined to save the entire œsophagus, if possible, instead of severing it at the level of the cricoid cartilage, and by careful manipulation I was able to strip the œsophagus and the mucous membrane from the tips of the arytenoid cartilages and larynx down to the base of the first ring of the trachea without perforating it.

The larynx, with the first ring of the trachea attached to it, was then severed from the trachea, and the trachea was stitched to the skin in two flaps formed by the sides of the original tracheotomy incision, which had embraced the second and third rings. The soft parts were then brought loosely together with sutures without any dressing in the pharynx; and a small, soft rubber stomach-tube was inserted into the stomach through an opening left in the upper portion of the dressing. This was inserted, thinking that there might be a necessity to use it for introducing nourishment; but it was found unnecessary, and it did some harm. An hour had been occupied in the whole procedure—anæsthetization, operation and dressing. The patient was then put to bed. He was carefully watched. I stayed with him for sixteen hours; and during that time I instructed a number of young men connected with the throat and surgical clinics of the hospital how to take charge of the case. Two members of these staffs were with him constantly for eight hours. Twice during that time the man would have died had not skilled hands been present to remove mucus from the tracheal tube. It is to the close attention of these young men for the first eighty hours, and to the admirable service of our chief surgical resident, Dr. Hager, that this man chiefly owes his life, for the attention after such an operation is far more important in a clinical point of view than the operation itself, all-important as it is. There was a good deal of oozing alongside of the œsophageal tube. On the third night this tube became detached and we did not re-introduce it. Enemata were used for four or five days, and then we gradually began to give food by the mouth. At each attempt at swallowing, a piece of gauze was applied above the tracheal wound and the parts were pressed close together while the patient swallowed. There was a little trickling for a few days, but this ceased. It was interesting to watch the œsophagus during swallowing, before the external wound contracted. It was easy to see that the œsophagus opened when the man took water. There has been some doubt whether there is a mechanical distention of the mouth of the œsophagus in glutition, or whether there is some such action of the œsophagus itself. In this case it certainly did open to receive the water. The man has made an uninterrupted recovery. There has been no attempt made to use a voice tube, and for two reasons. In the first place, I know of no one in

this city competent to make one, and in the second place, I do not wish to put anything into the wound that would irritate it until there remains no doubt in regard to the question of recurrence.

You will notice in examining this patient that there is now no connection between the trachea and the nose. I wish here to call attention to an important physiological point. Of late years a number of German surgeons—Aschenbach and others—and notably MacDonald, of London, and Bosworth, of New York, have been making experiments in reference to the physiology of nasal respiration by the use of tubes, etc. They assert that the air of respiration becomes fully saturated with moisture in the nose, and that consequently, being saturated when it enters the lung, it can receive no moisture from the lung. Therefore, they say, physiologists are wrong in stating that moisture is exhaled from the lung. In this case there is no connection whatever between nose and lung; and if you take a mirror and hold it over the tracheal opening you will see that it becomes covered with moisture. In this case the lungs do exhale moisture. Of course, here the conditions are different from the normal. I only wish to call attention to this point, as it seems to show that the older physiologists were right. There is still a small fistula above, which I think will close without difficulty, but it has no connection whatever with the trachea.

From the history of this case, I took it for granted at first that it was a papilloma recurring upon the seat of a former growth; but when a portion of it was examined by a microscopist it was pronounced sarcoma.

After extirpation of the larynx the growth was pronounced to be cylindrical epithelioma, or a destructive adenoma or adeno-carcinoma invading the arytenoid and thyroid cartilages as well as the soft parts. You see it here in the specimen, nearly filling the cavity of the larynx, proceeding from the left side mainly but extending slightly to the right side, penetrating necrotic portions of both wings of the thyroid cartilage so as to present externally and involve the cutaneous surface likewise. Whatever it may be, there is no doubt of its malignancy.

The question whether benign growths are ever transformed into malignant ones is important. It is the generally received opinion that benign growths are sometimes, by further irritation, converted into malign tumors. A collective investigation into the subject by Semon, of London, has shown the fallacy of this opinion as far as it refers to the laryngeal neoplasms. Certainly there was in this case no conversion of a papilloma into a malignant growth. The malignant growth became developed many years later upon the site from which a benign growth had been removed.

There is one clinical point that has been a revelation to me; and that is the freedom from pain, freedom from cough, and freedom from dysphagia. Should there be no recurrence in this case, we have every reason to be satisfied with the result. Should recurrence ensue, the patient will have been relieved from suffering for some time.

A number of years ago, when I investigated this subject, I was opposed to the operation in the main, as I am still. This is an exceptional case; and it is only in exceptional cases that laryngectomy should be performed. At that time Dr. Czerny, of Heidelberg, wrote to me that if I could only see some of his patients and witness how free from pain they were, I would believe that the operation was a justifiable one. This case verifies his remarks. The patient is now happy; whereas for many months before the operation he had been miserable.

The man is wearing a single rectangular-like tube with as little paraphernalia about it as possible.

ELECTRICITY TO FACILITATE THE INTRODUCTION OF THE EUSTACHIAN CATHETER.

BY A. K. BOND, M. D.,

Lecturer on Diseases of Children and Dermatology in the Baltimore Medical College.

A middle-aged gentleman came to me in June, 1892, with a recent perforation of the drum of the right ear. In course of treatment I found the passage of the eustachian catheter through the nose very difficult and painful on account of swelling of the nasal tissues, and spasm of the muscles in the posterior part of the nasal floor. Sometimes by prolonged and gentle pressure the catheter tip would, after five or ten minutes, pass into the pharynx; but at other sittings the great pain and prolonged spasm with bleeding would cause me to omit catheterization for the day. The curve of the hard rubber catheter was about as slight as was compatible with its application to the mouth of the eustachian tube.

After a week of such experience it occurred to me that the nasal walls might be so relaxed by the passage of an electric sound (which I was at the time using in a case of acute nasal stenosis) that the catheter could be quickly passed in without difficulty. I therefore, at the next visit, attached the sound, which had an insulated aluminium bulb about twice the diameter of the catheter, to a ten-cell battery of my fifty-cell chloride of silver galvanic battery, and passed it through the right nostril into the pharynx, the swelling and muscular spasm yielding gradually and painlessly before it. Quickly withdrawing the sound, I passed the hard rubber catheter easily into the pharynx, much to the surprise and delight of the patient, who had come to regard catheterization as an exceedingly painful operation.

It may be objected that the application of cocaine would have accomplished as much, but in my opinion the use of electricity is a much simpler and more scientific method.

Not having many opportunities to use the eustachian catheter, I would make the suggestion that a metal catheter with electric attachment, or a rubber catheter, with metal tip and attachments, might save much of that suffering and difficulty in the catheterization of certain cases which is familiar to the specialist. It may be that the method which I suggest is already in use, but I have seen no mention of it.

Mr. J. W. Davis, New York, has devised a kite for carrying a life-line from a vessel wrecked near the shore, and thereby effect connection with the Life Saving Service along the coast. Heretofore such connection has been made by projecting the life-line from a mortar on the shore across the wrecked ship. The successful application of the kite will serve as a very useful adjunct or complement of the mortar. According to the description, the kite is constructed to meet every possible indication, and is strong enough to stand any wind up to fifty miles an hour. It is made to carry a buoy to which the life-line is attached. In the description it is stated that "the weight of the buoy is a little less than the lifting power of the kite, when the forward movement of the latter is arrested, so that ordinarily the buoy will be held down to the water by the life-line, although the kite can drag it over reefs, bars and floating spars, obstructions which stop such devices as self-propelling torpedoes, etc. When the kite is traveling its lifting power diminishes, and it simply tows the buoy, so that it is possible to take ashore in this way a much heavier line than can be sent by rocket or shot."
—*Baltimore Underwriter.*

REPORT OF THE TWENTY-FIRST MEETING OF THE GERMAN SURGICAL ASSOCIATION, BERLIN, 1892.

REPORTED FOR MARYLAND MEDICAL JOURNAL BY DR. JULIUS FRIEDENWALD.

The German Surgical Association began its twenty-first session in Berlin on the 8th of June. The congress was fittingly opened by the dedication of the Langenbeck-haus. Von Langenbeck, who was for many years president and honorary president of the Association, has expressed the earnest desire during his life-time to erect a building suitable to the needs of the Association. His wish remained unfulfilled. At length, several years after his death, the society has erected a large handsome building in honor of the man whose name it bears and who was the most eminent surgeon of his day. The Langenbeck-haus has been built on the University Clinic grounds on Ziegel-strasse. It contains a large handsomely furnished meeting hall and apartments for surgical purposes. It was the dedication of this building that marked the opening of the session of the Association. There were assembled here the friends and pupils of Langenbeck in great numbers from far and near, to bear honor to his memory.

The memorial oration was delivered by the president of the Association, Prof. Von Bardeleben, the introductory address by Professor Von Bergmann.

Immediately after the celebration, the program for the day was taken up. Prof. Brauns (Tubingen) began with a dissertation on the surgical importance of our new form of military arms. The new form of arm is characterized by a change in the size of the bullet, which is of small calibre and so permits of greater velocity. The new form of powder also adds to the velocity. The speaker had experimented freely on dead and living animals to determine the effect of the Nantel bullet and comes to the conclusion that the wounds present different appearances according to whether the bullet is fired at shorter or longer range. At a distance of from 800 to 1,200 meters, explosions are produced only when the skull is penetrated; bones more frequently show bullet openings and are seldom shattered. An opening of 5 millimeters in diameter is presented at the point of entrance in the skin, a slit 6 to 7 millimeters in length at the exit of the bullet.

Fired at short or very short range, explosions are common and frequently produce considerable destruction of soft parts and bone, while the skin may only show the small, round, bullet opening. Bullets do not remain in the tissues when fired at a range of 1,200 meters; while shreds and parts of clothing are frequently found in the bullet canal. The Nantel bullet differs considerably from the lead bullet, in that the former does not change its shape in penetrating a part; this only occurs when it rebounds against very hard substances. It is not possible that the number of mortal bullet wounds will be greater in future than in former wars. The new bullet has many special advantages; in that probings and extractions are less frequently indicated and wounds are on the whole much more aseptic than in former wars. The experience of the physicians during the late civil war in Chili proves that the discovery of this new bullet marks an advance in humanitarian methods. Inasmuch as this bullet travels in a perfectly straight line from entrance to exit, the degree of damage can be determined with great accuracy. The use of a perfectly aseptic dressing is recommended as the first indication in the treatment of such wounds.

Dr. Reyer (Hannover) was the first to discuss this paper. He, too, had experimented freely with the new bullet and had come to the conclusion that the percentage of mortal wounds diminishes as the calibre of the bullet decreases.

He did not agree with the previous speaker, that bullets fired at short range produce severe shattering.

The next speaker, Dr. Messner (Munich), had closely examined into the question whether the heat produced by these bullets was sufficient to destroy organisms. In shooting through gelatin cultures of staphylococcus pyogenes or the bacteria of green pus, he found these germs developing usually in the bullet canal.

Prof. Helferth (Greiswald) showed some remarkable specimens in which great bone shattering had been produced by firing of bullets at short range.

Dr. Haase (Berlin) took up the question of the relative positions that hospital attendants should be placed at in future wars, and the location of hospital departments and ambulances.

The question of the immediate treatment of these wounds was then discussed. Langenbach (Berlin) believes that such wounds can be at once sewed up or closed up entirely with sticking plaster. Von Esmarsh, Trendelenburg, König, and others, thought this method entirely improper. The discussion was becoming endless when Prof. Thierch (Leipsic) arose and said "Let us leave these wounds *open*, but *close* the discussion."

On the second day, Gülerbich (Berlin) demonstrated a patient in whom he had resected several ribs for empyema, with excellent result, and Prof. Bramann (Halle) showed several patients from whom he had removed brain tumors. They had all recovered.

Prof. Czerny (Heidelberg) believed that trephining was a justifiable operation in many cases of insanity and while no immediate recovery could be expected, the regulation of the intra-cranial blood pressure was something from which much good might result.

Prof. Knöte exhibited a patient on whom he had resected a ureter for stenosis and replaced the healthy part with the pelvis of the kidney.

Reichel (Wurzburg) read a paper on "Hernia of the Ureter in the Inguinal Canal;" Barth (Marburg) "Histological Changes taking place in the Repair and Regeneration of Wounds of the Kidney;" Olsberg (Hamburg) "Kidney Glioma." Schlouge (Berlin) exhibited a number of patients who had recovered from actinomycosis. In case of head and neck actinomycosis recovery results most frequently in a few months.

When the lung is involved recovery usually takes place unless the pleura is attached and perforation results. When the retro-peritoneal glands are involved and pyæmia sets in, peritoneal actinomycosis also ends unfavorably. Dr. v. Eirelsberg (Vienna) had seen a case of actinomycosis recover after the injection of tuberculin.

Prof. König read a paper on our modern methods of treatment of joint tuberculosis. The mechanical treatment is the first indicated (extension, rest, etc.). The injection of iodoform can be employed in addition to mechanical treatment in some cases. The early resections that were formerly practiced are improper, but when sinuses, abscesses, great destruction of bone have taken place, a radical operation must be performed; in the worst cases amputation, in milder forms resection. In regard to the use of iodoform injections, it is necessary to remember that iodoform acts only locally and that every tubercular focus must therefore be reached.

At the opening of the third session, Dr. Thiers showed a patient on whom a syphilitic rectal stricture had necessitated the formation of an artificial anus; after the healing of the stricture he closed the provisionary anus.

Prof. Trendelenburg (Bonn) demonstrated a case of "Flat-foot" on which he

had operated. The bones of the leg just above the ankle were chiselled through, the foot straightened and the arches brought into such a position as to bear the weight of the body. He believed there was a relation between this conditon of "flat-foot" and profuse perspiration, and in his opinion the pressure on the plantar nerve reflexly produces a pathological increase of sweat.

Dr. Köhler (Berlin) showed a patient on whom a pyloro-plastic operation had been performed for pylorus stenosis. The patient recovered with perfect digestion and increase in weight.

A case of gastro-enterostomy was related by Dr. Hassler (Halle); and Dr. Krause (Altoona) presented a patient on whom he had performed successfully resection of the second branch of the trigeminus for intense facial neuralgia along the course of this nerve. A large section of skull on one side was chiselled out, and on account of severe hæmorrhage the wound was packed with iodoform gauze for five days. The patient was then again anæsthetized, the branch was sought and laid bare: it was found thickened and hyperæmic and was resected in that part of its course where it passed out of the foramen rotundum. The patient has since been relieved of her pain.

Prof. Bardenhauer (Cologne) showed several cases of resection of superior and inferior maxillary.

Dr. Cramer (Wiesbaden) read of a case of leprosy. He demonstrated the bacilli in softened parts of the nerves of the fore-arm. The patient had lost entire use of his arm. After curetting these softened foci, the parts healed up perfectly, and the use of the arm was restored to the patient.

Dr. Neuber (Kiel), in speaking of aseptic wound treatment, believed that moisture on the walls of an operating room was in many cases sufficient to prevent first infection. If this were carried out, he did not believe that thorough disinfection of instruments and dressings was always necessary.

Dr. Schimmelbusch (Berlin) disagreed entirely with the last speaker. To him infection through the air was quite insignificant, while thorough sterilization of instruments and dressings was always necessary.

Dr. Hartmann showed a cavalryman on whom he had operated for brain-abscess. During the war of 1870, the patient was thrown from his horse and dragged a considerable distance. After years he began to complain of pain in his head: this increased gradually, and not being able to get relief he sought surgical help. The region at which the pain was located was trephined, the abscess cleaned out, and the patient has since been entirely relieved of his pain.

Prof. Grawitz (Greiswald) then read a very interesting paper on his late studies in inflammation, after which discussion was opened on Prof. König's paper of the preceding day: the treatment of joint tuberculosis. In general the other surgeons agreed with Dr. König.

Dr. Schuchart (Stettin) read a paper on the transmission of tuberculosis through sexual relations. He showed that tuberculosis can be transmitted in this way without any external manifestation on the sexual organs. In a number of cases of gonorrhœal pus, he had found tubercle bacilli.

Dr. Gultz (Berlin) then read his statistics on "Anæsthetics," which he had collected by order of the Association. To his inquiries during first year 24,625 answers had been returned: last year 62 observers returned reports of 84,605 cases. During the first year there were six deaths reported: during the last year thirty-three. Of 109,230 anæthetizations during the two years there were thirty-nine deaths; 94,123 chloroform anæthetizations with thirty-six deaths, that is, one to 2,614; 8,431 ether anæsthetizations from a mixture of chloroform

and ether, with one death; 1,380 with a mixture of ether and alcohol, without a single death; 2,179 with bromide of ethyl without a single death; and 219 pental anæsthetizations, with one death. The crystallized chloroform is here recommended for general use; it does not cause unpleasant results like the ordinary chloroform, can easily be preserved, and patients are rapidly brought under its influence. The speaker believed that from the excellent results which the use of ether has shown for itself it should be generally employed.

On motion of Prof. Bruns, it was decided that the statistics should be carried on for another year.

Prof. Julius Wolff (Berlin) brought forth a patient, on whom he had entirely extirpated a cancerous larynx. Other surgeons in Berlin had refused to operate on the case. Through the generosity of Prof. Du Bois Reymond, an artificial larnynx was devised, with which the patient could not only speak, but even sing.

Prof. Olshausen then showed patients from whom the uterus had been entirely extirpated. He did not believe that if the operation was properly performed that it was as dangerous as was usually supposed.

Prof. Riedel (Jena) recommended the use of the "Mannesmann" hammer instead of the ordinary wooden hammer, which is usually used in surgery and is much disfigured by sterilization; he had a hollow metal hammer constructed of Mannesmann rods, which he considers very serviceable.

Dr. Urber (Leipsic) then read a paper on the operative procedures necessary to relieve the spinal cord of the pressure produced against it by a crushed-in spinal column. The speaker makes two parallel incisions, one immediately over the injured part, through skin and muscle, chisels through the spinal column, raises up the fractured part and relieves the compressed cord. The parts are then returned and allowed to heal. Prof. Thierch (Leipsic) has performed this operation successfully.

Dr. Philipp spoke next on the use of pental for the production of anæsthesia in children. The results of this anæsthetic are excellent. Children are not troubled with nausea afterwards and are able to play. Dr. Schede (Hamburg) had, however, seen twelve pental-anæsthetizations in adults, with asphyxia and syncope in two cases.

Dr. Schleich (Berlin) spoke next on hypodermatic injections for the production of local anæsthesia. He believed that local anæsthesia could be better produced by other than cocaine solutions. He recommended especially the injection of normal salt solution. The injection in the skin of sugar solution, or even sterilized water, produces local anæsthesia.

Dr. Körte (Berlin) then read his report on the surgical treatment of purulent peritonitis. Although he believed in draining the abdomen he did not believe in flushing, inasmuch as adhesions are thus broken up.

Dr. Lauenstein next read a paper on the presence of adhesions in the abdomen as cause of severe colic. These adhesions may be between the intestine and liver, between parts of the intestine and so on. In a number of cases, in which he relieved these adhesions, permanent relief resulted. These adhesions are frequently formed after abdominal operations.

With the election of Prof. König as president, this session of the congress closed.

Pilocarpine hydrochlorate hypodermically, conjoined with the internal use of camphor, is reported to have excellent results in *status epilepticus*.—*Med. Rec.*

THE MARYLAND MEDICAL JOURNAL.

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A. K. BOND, M. D., Editor.

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BALTIMORE, JULY 16, 1892.

Editorial.

THE NEW YORK CITY BOARD OF HEALTH.

The following editorial in a New York paper refers to the charges of partisan prostitution of the Board of Health of that city. It appears that Drs. Janeway, Prudden, Abram Jacobi and Stephen Smith have resigned their honorary positions in that Board on the ground that faithful medical employees have been brutally entreated at the demand of pot-house politicians, by being called upon to "hand in their resignations;" or, in other words, that reputable and competent men have been put out of office without complaint or pretense of charges "for cause."

The editorial referred to is as follows:

"The trouble in the Board of Health is most unfortunate for the public interests. Four of the leading physicians in the city, whose professional reputation stands deservedly high, have severed their connection with the Board as consulting physicians. The names of Drs. Janeway, Jacobi, Prudden and Stephen Smith are too well and favorably known all over the city to make it necessary to enlarge on the seriousness of the loss the city sustains by the withdrawal of their assistance from the Health Department.

The reason assigned for their action is that the sanitary service is run in the interest of the politicians and not of the public health. Dr. Ewing, who has for twenty years been Sanitary Superintendent, was forced out of the important position by President Wilson, it is alleged, in order that a politician or a person demanded by a political organization might be put in his place.

If any department of the city government ought to be kept entirely out of politics it is certainly that department to which is entrusted the guardianship of the public health. If it is not, no reputable physician will desire to have any association with its work.

We have no knowledge of the correctness or incorrectness of the conclusions reached by the retiring doctors. President Wilson strongly denies that any political considerations influence the management of the department, and gives alleged official reasons for Dr. Ewing's removal. But such doctors as we have

named ought certainly to be the most competent judges of the capacity of a Sanitary Superintendent.

It is to be hoped that the trouble will be stopped without any delay."

Our comments are the following:

1. This picture of the treatment of sanitary officers is so general that it may be taken as a legitimate likeness of one side of our American system of political misgovernment. Except in times of startling danger, our rulers look upon the sanitary interests of our cities as mere playthings or tools to work ward politics with. A sanitary officer is considered neither better nor worse than a licensed ashman.

2. The medical profession rarely interests itself in the tyrranous misdoings of the city "machines." When it does take a hand, or when some society enters a protest, there is probably some personal reason for it, as, for example, when some favorite and popular member is the victim. The principle of the matter is commonly ignored.

3. In regard to the New York Board, it is probably true that, at no time in the thirty years of its existence, has it been altogether free from the slime of the political serpent—sometimes worse and sometimes not so bad. And the same statement is without doubt true in other cities and towns. But this does not answer or mitigate the charges against the present administration. Past evils condone no present ones.

4. The President of the Board says the charges are not true, because the workings of his office are just as efficient, and the public is just as safe as before. He probably cannot truthfully deny the intermeddling of political fingers. He is not unlike the car-pedlar who had gum drops and carpet-tacks as alternatives to offer to the purchasing public; if the public says "I never eat candy" out comes the carpet fasteners. He is charged with ignominiously expelling a worthy young physician or two, and he replies "But do you not see we have no cholera nor small-pox?" His friends and adherents are probably satisfied that the logic of events, in this manner, sets aright all wrongs done to former medical officers. We know, however, that "practical politics" is a cut-throat game and has regard for neither justice, mercy or logic.

Since the above was written other resignations have been presented, so that comparatively few of the representatives of the Academy of Medicine, or of the medical staff of the Willard Parker Hospital for Infectious Diseases, continue in their appointments. If the names have been reported correctly, among those who have resigned are Drs. Janeway, Jacobi, Prudden, Stephen Smith, Stimson, Derby and O'Dwyer.

THE MEDICAL LAW AS IT CONCERNS DOCTORS NOW PRACTISING.

The new law relates only to persons who shall after the date of its passage begin the practice of medicine within the State. In regard to any person who may

have previously practised in Maryland, it is silent. These persons occupy after its passage exactly the legal status which they occupied before. The new boards of examiners are not expected to indorse their claims as practitioners, nor to condemn them as in any way culpable. They are simply to ignore them, and to confine their attention to future practitioners.

Moreover, the new Boards of Examiners may not molest any person hereafter beginning practice in Maryland, unless they have before them reasonable proof that such persons have never, previous to the passage of the law, practised medicine in any other of the United States.

It will appear, therefore, that considerable caution must be exercised in the arrest of practitioners who hail from other States. Many years will pass before the law will be of much use in keeping itinerant doctors out of Maryland.

A good beginning has, however, been made, and its beneficent influence in restraining young graduates of home colleges will immediately be felt.*

Reviews, Books and Pamphlets.

Annual of the Universal Medical Sciences. A yearly report of the progress of the general sanitary sciences throughout the world. Edited by CHARLES E. SAJOUS, M. D., and seventy associate editors, assisted by over two hundred corresponding editors, collaborators and correspondents; illustrated with chromolithographs, engravings and maps. Five volumes, 8vo., 1892. The F. A. Davis Company, publishers, Philadelphia, New York, Chicago and London. Australian agency, Melbourne, Victoria.

This set of volumes, appearing now in the fifth series, is altogether a very attractive addition to the practitioner's library. It presents the new facts brought out during the year in each department of medicine and surgery, in the form of a condensed review by some eminent worker in each department, with copious references to the journals or books in which new facts have been published. The type is clear and good. The series is worthy of hearty commendation.

The Continuous Use of the Bromides. By L. W. BAKER, M. D., Superintendent Riverview Sanitarium for Nervous Invalids, Baldwinville, Mass. Reprint from *Medical Register*, 1888.

The Semi-Private Care of Epileptics, by the same author of above. Reprint from *Boston Med. and Surg. Jour.*, Dec. 17, 1891.

The Second Year's Work in Diseases of the Rectum at the New York Post-Graduate Hospital. By CHARLES B. KELSEY, M. D. Reprinted from *N. Y. Med. Jour.*, March 26, 1892.

We have received from the F. A. Davis Co. an announcement concerning the new tenth edition, author's final revision, of Dr. D. W. CATHELL'S book on *The Physician Himself*, and Things that Concern his Reputation and Success. It is expected that this, the author's *last* revision of one of the most useful, successful, and popular medical books ever published, will be ready for delivery about August 1, 1892. It will be brought to perfection, as far as human effort can attain, and enlarged to nearly 350 royal octavo pages, bound in extra cloth. The price will not be increased, but will remain at $2.00, net, post-paid.

*Copies of the Law may be obtained at the JOURNAL office at ten cents each.

Medical Progress.

WHAT MICROSCOPE SHALL I GET?

To this question Dr. Beggs, of St. Louis, replies in the *Medical Fortnightly*, June, 1882. In closing his paper he says:

As I have indicated, it is a mistake to suppose that for medical purposes an expensive microscopical outfit is necessary. Neither microscope nor objectives need be expensive. The stand should be as simple as possible, but should also be well made. It should be steady, not trembling at the least jar. The stage should not be too high. Nearly all of the high-priced microscopes made in the United States and England are, in my opinion, open to this objection. If the stage is too high the hands easily tire, a difference of half an inch in the height of the stage having a very appreciable effect on the ease of manipulation. Clips may be of advantage, or they may be a decided nuisance. They should certainly be removable, and in all ordinary manipulations, removed. Their only value is in fixing a preparation immovably in a definite position.

The combination of ocular and objectives generally recommended with microscopes is not the best for medical purposes. Ordinarily two oculars (2 and 1 inch or 1½ and ½ inch) and two objectives (1 and ¼ inch, or ¾ and 1-5 inch) are recommended. Of the combinations of oculars, the first mentioned is preferable. It is seldom desirable to increase the magnification by means of the eye-piece. Definition is not increased, although the apparent size of the object is, and there is a loss of light and distinctness which are not compensated for by the increased magnification.

Neither of the combinations of objectives mentioned is advisable. A combination of a ½ or ¾ inch with a ⅛ inch is far preferable. The first gives a sufficiently low power for ordinary purposes. It can generally be divided, and then gives sufficiently distinct pictures if very low power is necessary. For a high power for medical purposes, the ¼ or 1-5 inch does not give sufficient amplication, and the ⅛ is to be preferred. It must be remembered that to be able to find a preparation, that which is known to be there is not what is expected of the objective. The tubercle bacillus and the gonococcus must be shown with sufficient amplification and distinctness to be readily diagnosticated by one not an expert microscopist. For this purpose the 1-5 is not enough. The ⅛ fills the demand, and the additional expense is slight.

With such an equipment as I have described the necessary work which every physician should do with the microscope can be accomplished. It is also not absolutely necessary to expend $75 or more in the purchase of such an equipment. Half that sum will be sufficient. Were it not for the ban which the protective tariff places upon importation, not more than from $20 to $40 would be necessary. While the tax upon education has been removed as far as colleges are concerned, it is a fact to be regretted that full and free opportunities for scientific education and work are denied the individual.

A CAUTION TO PRESCRIBERS.

Commenting on a recent death in this city caused by a druggist misreading a carelessly written prescription, in which "tinct. opii c." was used to indicate paregoric, a correspondent of the *Virginia Med. Monthly* rightly urges that all physicians should accustom themselves to stating at the top of the prescription whether it is for an adult or for a child. He says:

"I trust you will excuse me if I embrace this opportunity to emphasize the importance of physicians always stating on their prescriptions *whom they are for* (unless, of course, there is good reason for not doing so), and particularly always, if for *an infant* or *small child*, to say so. The importance of this is so axiomatic, it seems a work of supererogation to attempt an elucidation of the point. If a prescription is presented to a druggist to be prepared, in which the dose of laudanum is twenty drops, to be repeated in two hours, if he sees by the prescription that it is for an adult, without hesitation he goes ahead and puts it up. But suppose the doctor says "for an *infant fourteen days old*," the druggist would at once know that the doctor did not intend to give a fourteen day old infant twenty drops of laudanum every two hours. If the doctor simply writes his prescription and does not say whom it is for, as alas! so many do, and as very likely this Baltimore doctor did, any druggist would prepare it under the impression that it was for an adult, when really it is for an infant, and the doctor intended to write for paregoric, but inadvertently omitted the camph., or C. I know I have stated a suppositious case, but all druggists have exactly similar experiences."

ARTERIO-SCLEROSIS.

Writing upon this subject in the *Montreal Medical Journal*, June, 1892, Dr. Ross enumerates its causes as follows:

The cause of this disease is now generally conceded to be over-strain of the vessels. The onset of arterio-sclerosis depends (Osler), in the first place, upon the quality of arterial tissue which the individual has inherited: and, secondly, upon the wear and tear to which he has subjected this tissue. That the former is the more important is shown in cases where the disease occurs in early life, where none of the recognized causes have existed. For example, a man of about 30 years may have arteries of 60 years, and a man of 40 years may have arteries as much degenerated as they should be at 80 years: and this was found in the case which I bring before your attention to-night.

Entire families sometimes show this tendency to early arterio-sclerosis, a tendency which cannot be explained in any other way than that in the make up of the machine bad material was used for the tubing. More commonly this disease results from the bad use of good vessels, and among the causes of this condition are the following:—

1. Chronic intoxications. 2. Over-eating. 3. Over-work of the muscles. 5. Renal disease. 5. A cachectic state of the system or some cause that alters the constitution of the blood and weakens the heart's action, such as prostrating illness and the mental conditions of anxiety and grief.

THE GERMAN PROFESSOR ON HYPNOTISM.

"Hybnodism," the German professor said thoughtfully, "vos a mendal disorder dot vos raging brincipally in der noosebapers. It vos a hypertrophy auf der imachination, undt der writers on mendal pheenomenons vos first attacked. You migbd call it a sort ouf writer's cramp auf der prain. Der ingrediences peen made auf a fool undt a rascal. Mix thoroughly undt set avay in a cool blace. Bud one well-authendicated case has peen reported, undt dot vos told py a notorious liar auf France. As a defence for der lawyers to sed up in murder drials ya vould peen a pudding, as Schiller saidt; but its brincipal use so far already h s peen confined to sheap novels undt skyentific makazines. Fife touand years ago a Greek philosopher hybnodized a rooster-shicken mit a straight chalk-mark on der floor, undt now, in 1892, der skyentific beeples discofer dot

you can hybnotize beeples auf dey aindt got as much prains as dot rooster. Nature got hard feelings towards a vacuum undt auf you aindt got any intelligences auf your own you can absorb dot from somepody else. It vos a choyful surbrise to some peeble's headts to get a mind inside auf dem py hybnodism auf dey didn't had some alreaty by natural. It's bedder, young mens, dot you cultivate some prains auf your own, aber you debend on hybnodism aber hypodermic inchections auf mendality. In der meandimes I can hybnodize dis class more expeditiously undt skimultaneously mit a glub. It's bedder you enchoy dis pecooliar phleenomens vhile she is goin', pycause she vill soon go down der stream auf time pehind der plue grass, der roller skate, Koch's lymph, Keeley's gold cure, undt pig-headed canes.—From *Judge*, in *National Popular Review*.

RESECTION OF THE OPTICO-CILIARY NERVES.

In the *Virginia Medical Monthly*, July, 1892, Dr. J. J. Chisolm discusses this important operation and gives the result of his personal experience with it: The pains in the eye disappear promptly and, as a rule, permanently. The patient retains a good-looking eye, worth the risk of having the pain return to it at some future time, when the more radical operation of enucleation, if demanded, can be performed.

Should this second operation not be required, he has been saved the constant thought of having been mutilated, which embitters his whole future life. He also escapes the daily annoyance of using an artificial eye, which gives a lot of trouble, as every wearer of one too well knows.

Too many good-looking, but dangerously painful eyes, have been enucleated, when this much preferable operation might have been substituted. I am fully aware of the many accidents which have occurred in the experiences of other ophthalmic surgeons—how hæmorrhage has been excessive; how dangerous, and even fatal, cellulitis has followed the exposure of the ocular tissues; how the cornea has sloughed, and endless troubles engendered, as the sequel of the operation.

I will only say that, in my large experience, no such accident has happened to me. I may have avoided many of them by using, at all times, sterilized instruments; also by discarding, at an early period, the more serious exposure of the socket-tissues by not doing myotomies, nor by being desirous of bringing the optic nerve into view, so, as it were, to make the section under the eye. I always felt that this bold—I am rather disposed to call it by its proper name. *rash*—dissection invited the serious accidents which afterward followed.

Unfortunately, I am not able to trace all of my cases. Several of them I have seen at intervals of several years after the nerve-section. They had enjoyed life undisturbed by any return of the former pain. Others promised to report promptly should they not be comfortable. From these I have not heard, and therefore presume that they have had no occasion to write. In only four cases, coming to my knowledge, has it been necessary to perform enucleation.

In suitable cases, I feel assured that neurotomy is far preferable to the mutilation of enucleation. I think that this will be accepted by all without a dissenting voice, if the dangers which some have met with can be avoided. This can be, in a measure, secured by adopting the simpler operation without cutting the muscles, which, when properly performed, is, in my experience, equally effective with the more complicated methods, and with much less risk. It is also an operation which even the most timid patient will accept.

Notwithstanding the dangers ascribed to neurotomy, many of which are avoid-

able, I think it would be well if those who have discarded this good operation would put it again on their list of available methods.

Knowing its defects, and also familiar with its many advantages, were I required to make a choice between the two operations, enucleation or neurotomy, for a member of my own household, I would not hesitate a moment in the selection, and would accept neurotomy.

PREVENTION OF URIC ACID GRAVEL.

In an instructive article upon the "Chemistry and Therapeutics of Uric Acid Gravel and Gout" (*Lancet*, June 25, 1892), Sir W. Roberts, after referring to certain publications of his own on the subject, says:

The character of the urine was shown to be most affected by the digestion of food, by prolonged fasting, and by sleep. It was found that a meal, whether it was composed of ordinary mixed food or of purely animal or purely vegetable substances, produced two constant effects—it depressed the acidity of the urine and increased its volume. And, conversely, prolonged fasting raised the acidity and diminished the flow of the urine. During the hours of sleep, which are also of course hours of fasting, the acidity of the urine reached its highest point and the flow of the urine reached its lowest point. The proportion of uric acid in the urine—that it is to say, its percentage—was found highest during the time of sleep, but the hourly excretion was highest during the hours following a meal. Now, if we apply these facts in the light of the evidence previously adduced in regard to the factors which determine the precipitation of uric acid in the urine, we arrive at the conclusion that the period when there is most risk of precipitation in the kidneys is during the time of sleep, and especially in the early morning during the two or three hours preceding breakfast. The deposition of uric acid is most imminent when there is a conjunction of the several conditions—that is to say, when the flow of urine is very scanty, when the secretion is hyperacid, and when it is rich in urates. Such a conjunction is most fully developed during the period of sleep. Sleep is a time of fasting, and therefore a time of hyperacidity of the urine—a time of recumbency and bodily immobility, and therefore a time when the renal stream approaches nearest to stagnation, and loiters longest about the purlieus of the kidneys. On the other hand, during the day and the waking hours the recurrence of the meals keeps the urine at a low degree of acidity, or even renders it for a time neutral or alkaline, the renal stream is comparatively full and rapid, and its descent from the kidneys is favored by the force of gravity. During these hours, therefore, the risk of uric-acid precipitation is reduced to a minimum, even in persons who have a distinct tendency that way. For, as I have repeatedly had occasion to observe, the urine of calculous subjects exhibits precisely the same cyclical diurnal variations as that of healthy persons, though not always in so marked a degree.

A study of these facts indicates that if we safeguard the night, the day may be generally left to take care of itself. This theoretical deduction is fully in accordance with experience in the treatment of uric acid gravel. In the milder cases a single full dose of the alkalizing agent taken at bedtime suffices to prevent the recurrence of the colicky pains and discharge of uric acid concretions. For this purpose the citrates and bicarbonates of potash and soda are the most effective. The citrate of potash is, perhaps, on the whole, the best preparation to employ; it has very little taste, and it sits comfortably on the stomach. The dose for an adult should not be less than forty to sixty grains, dissolved in three or four ounces of water. In severer cases a single dose is insufficient, and the early morning urine will still exhibit a morbid disposition to pre-

cipitate uric acid. In such cases a second but smaller dose should be taken about the middle period of the hours of sleep.

The essential thing in the prophylactic treatment of uric-acid gravel is to guard the urine from precipitating within the precincts of the kidney. And we shall practically have attained our object if we succeed not in altogether preventing precipitation, but in postponing it until the urine has quitted the kidneys. A postponement for a short time—even half an hour—may make all the difference between a precipitation which is fraught with pain and peril and a precipitation which is perfectly harmless. Now, the protective effect of an antacid dose extends a good deal beyond the point at which the urine is rendered actually alkaline. For, although all acid urines of medium density precipitate uric acid sooner or later, the time of the occurrence of that precipitation is immensely influenced by the degree of acidity of the urine. Other things being equal, the more acid the urine the earlier is the precipitation; and the less acid the urine, the longer is precipitation postponed. An antacid effect, therefore, which is too feeble to render the urine actually alkaline, may be quite sufficient to depress its acidity to such a degree as shall postpone the time of precipitation until the the urine has escaped from the kidneys and even from the bladder.

The use of mineral springs in the treatment of uric-acid gravel demands a word of comment. A sharp distinction must be drawn between alkaline springs and non-alkaline springs. Alkaline waters, such as those of Vichy, which are largely impregnated with carbonate of soda, have the power of alkalizing the urine, and therefore absolutely protect against uric-acid gravel during the period of their use. But the non-alkaline waters have no such power, and their beneficial action is due to the fact that they greatly increase the flush of the urinary stream and thereby promote the carrying down of concretions already lodged in the precincts of the kidneys. Their efficacy in this direction is quite undoubted; but it is, I think, equally undoubted that the drinking of equivalent quantities of distilled water would be just as efficacious.

THE RELATIONS BETWEEN CANCER AND CHRONIC INFLAMMATION OF THE BREAST.

In closing an elaborate review of certain diseases (especially the cystic) of the mammary gland, Dr. Robinson (*Lancet*, June 25, 1892) remarks:

We now consider the relations of carcinoma to those cases of chronic interstitial mastitis where the connective-tissue changes are marked and the cysts only small and pea-like. That the two are often in association is a well-known fact. In many carcinomatous growths we get evidence at the margin of chronic inflammatory change, and the latter is possibly a stage in the evolution of the carcinoma. Raymond Johnson and Beadles at the Pathological Society in April last read papers on these changes, and were inclined to think that carcinoma has a distinct relation to chronic interstitial mastitis. This view has its strenuous opponents, who urge that such a condition is only an accidental association of two pathological lesions, and that there is no causal relation between the two. However, the greater the number of examples, the stronger the evidence in its favor, and I must own that previous mastitis seems to have some very definite relation to the subsequent carcinoma. Two rare cases of scirrhus have come under my notice, which form strong links in the chain, where scirrhous nodules were disseminated in breasts, showing the most marked signs of chronic interstitial mastitis. If we allow, then, that this chronic inflammatory change has some relation to the subsequent neoplasm, what bearing has this on prognosis and treat-

ment? We must remember that in giving a prognosis other factors, as age and hereditary tendency, have to be reckoned with. After observing many cases of chronic interstitial mastitis, we see that the majority often remain stationary. With this knowledge the most advanced surgeons could not press strongly the claims for a more frequent removal; but, at the same time, with this knowledge certainly we are more on our guard, and any marked development of pain or increasing thickening or skin adhesion may be a sign warning us that the time for hesitation is past and action must be taken.

MEDICINE IN JAPAN.

In the *Southern California Practitioner*, Dr. McGowan writes thus:

Three systems of medical practice prevail in Japan: The old Japanese, which consists, as nearly as I could ascertain, in a complicated system of massage, combined with hot baths and the use of hot drinks. This from time immemorial has been in the hands of the blind. They get good fees, and I am told not unfrequently accumulate handsome fortunes. A peculiarity of their mode of massage is that they rub downward always, instead of upward. The Chinese system, which, slightly modified by Dutch influence, was the prevailing one before the introduction of the European some twenty-five years ago. This is really not a system at all, as there are no schools of medical education in China, and no generally recognized medical curriculum. All knowledge under this system is transmitted from father to son, and passes not out of the family. Under some circumstances this might give rise to a keen class of specialists, but a Chinaman never attempts to surpass his father in knowledge, and hence we find that the healing art in China and those countries under direct Chinese influence has not advanced for ages. Neither of these systems of practice is at present recognized by the Japanese Government, and official impediments are constantly placed in the way of their practice. About twenty-five years ago a general university was established in Tokio, with a medical department, and the best teachers obtainable in Europe were imported at high salaries for its instructors. The medical corps was principally made up of well-grounded, broad-thinking and painstaking Germans. The system of sending picked scholars to American and European universities to study general medicine and specialties was inaugurated and fostered by the Government. Thus there soon grew up a new school of native physicians, brilliantly prepared for work and quite competent to take charge of the education of their countrymen. At present the medical department of the university is almost entirely in Japanese hands.

INFLUENZA AND PREGNANCY.

At a meeting of the West Kent Medico-Chirurgical Society, on May 6th, 1892, Dr. Horrocks read a paper on Influenza during Pregnancy and the Puerperal State. 1. Influenza during pregnancy: The phenomena of pregnancy generally are in no way altered or modified by influenza, although some of the symptoms, such as retching, vomiting and coughing, may cause rupture of the membranes and so cause miscarriage. 2. Influenza during the puerperium: Influenza may attack a patient after child-birth, and its symptoms are apt to be confounded with those of puerperal fever. The differential diagnosis is that the influenza does not affect any of the natural processes taking place during the puerperium. The milk is not lessened; the lochia are unaltered; the uterus involutes; *vice versa* pregnancy and the puerperium only slightly modify influenza. Advanced pregnancy intensifies the dyspnœa if present, and perhaps the blood changes of the puerperium may intensify the fever.—*Lancet.*

GENERAL TUBERCULOSIS; DEATH FROM ACUTE PNEUMONIA

Dr. L. Emmett Holt, at a meeting of the New York Pathological Society, presented the above specimens. A female child, aged three and a half years, with tuberculous antecedents, who had suffered for one year before death from tubercular glands in the neck. In the summer of 1891 she had an ordinary attack of entero-colitis, after which she remained delicate, moderately emaciated, and in a generally wretched condition. An examination of the chest in the middle of September showed only coarse scattered râles. There were occasional attacks of intestinal trouble during the fall, but no blood appeared in the stools. During October there was considerable improvement in the general condition, and she gained in weight. During November, however, she failed visibly and became exceedingly irritable if disturbed, but dull and apathetic if left to herself. Photophobia was quite marked; in fact, from her previous history, it seemed highly probable that a tubercular meningitis might be developing. A record of the temperature was kept, but no rise occurred until nearly the end of November; it then ranged between 100° and 103° F., continuously for one month. A few more râles were found in the chest, but no increase in the nervous symptoms. Eleven days before death the temperature suddenly rose to 104° F., and during the remainder of the disease it fluctuated irregularly between 101° and 104.5° F. With this high temperature there was an increase in all the pulmonary symptoms—cough, prostration, dyspnœa, etc. Signs of complete consolidation of left lower lobe soon appeared, and a little later similar signs over the right base behind. She died of exhaustion.

At the autopsy, the brain was found perfectly healthy. The bronchial glands were greatly enlarged, especially on the right side, where they formed a mass of some size about the right bronchus, one and a half inch in diameter and three-quarters of an inch thick. These glands were cheesy, but not suppurating. In the upper lobe of the right lung there were scattered nodules of tubercular pneumonia from one-eighth of an inch to half an inch in diameter, cheesy at the centre, the intervening pulmonary tissue being quite healthy. At the anterior border of the right middle lobe the oldest process was located. On section, this portion showed fibrous tissue surrounded by old cheesy masses, and here the lung was adherent to the pericardium. The lower left lobe was uniformly consolidated, of a reddish-brown color, with a thin layer of recent lymph on its surface. In the upper lobe of the left lung a circumscribed nodule of pneumonia was found, about one and a half inch in diameter, of a brownish-red color. On section, the rest of the lobe was found to be healthy. The lower lobe was uniformly consolidated, of a grayish-red color, slightly mottled, and showing a very slight pleurisy on its surface. The microscopical examination of the lungs showed a process having some of the characters both of a lobar pneumonia and of a broncho-pneumonia, but not quite those of either. There was not much fibrin in the alveolar exudate, but the pus and epithelial cells were very numerous. The spleen, liver and kidneys showed no essential changes. The small intestine was healthy throughout. The colon showed about a dozen old ulcers, chiefly in the rectum and descending colon, the largest one being over an inch in diameter. The mesenteric glands were all enlarged and cheesy.—*Med. Rec.*

THE THERAPY OF ECLAMPSIA.

The therapy of eclampsia has heretofore been one of pure empiricism. In distinction to the largely used treatment by chloroform anæsthesia, which has been so extensively employed, as it was also at this clinic, I prefer the use of mor-

phine in large doses, as suggested by G. Veit. As an initial I give 0.03 gramme hypodermically, and if the convulsions do not cease soon follow it by additional doses. In the course of treatment we seldom give over 0.06 gramme, or indeed altogether, although in cases that progressed chronically we have, during the course of several days, given much more; in one case giving as much as 0.27 gramme in four days, with good results to the mother.

When the condition of the pupils or of the pulse would indicate that the further exhibition of the drug is not advisable, and in case the attacks still continue, I substitute chloral, by rectal injection, in 2.0 or 3.0 gramme doses.

The use of chloroform seems eminently suited to those comparatively rare cases, where the attacks return after pretty regular intervals. In all other cases one must either prolong the anæsthesia for a very long time—which to us does not seem advisable—or else administer an anæsthetic at the first intimation of the approach of an attack; in the latter case, however, the remedy always comes too late to abort the attack.

During the continuance of the eclampsia, we make no use of either diaphoretics, bromides, wet-packs, or baths. Indeed, we shun all unnecessary handling of the patient, because this only too frequently will excite an attack. There have been cases in which a careful digital examination of the uterus, the expression of the placenta, a change of the patient's bedding, and even the puncture of the hypodermic needle, have been sufficient to excite a convulsion.

When, in deep coma, the rattling in the upper air passages becomes continued, asphyxia is imminent. This can be prevented by bending the patient forward over the side of the bed, so that the head is greatly lowered. In this way very large quantities of mucus will be discharged from the mouth, the respiration will become free and the cyanosis will disappear. The mucus may also be removed with small brushes of cotton or small sponges, which are inserted in the fauces, one after the other, by the dozen. In this way the same results are obtained. In many cases I feel convinced that we have saved our patients from an immediate death from asphyxia by these means. I also claim the great importance of the watchful care of a physician at the bedside of the patient, so as to be always ready in case of any such emergency. In Löhlein's recent publications on the subject we may read that Schatz recommended the frequent sinking of the head of eclampsic patients, but apparently not for the same reason.

Regarding operative interferences, V. Herff's recently recommended practice of rupturing the amniotic sac in order to accelerate the birth, is at all events worth the trial, and in multiparæ may be regarded as a pretty certain means of accomplishing this end. The frequent use of the forceps in cases of well dilated cervix with a deep position of the head, is equally recommended on all sides. Version, for instance, in cases of a contracted cervix, and extraction with the aid of free incisions, does not seem to me to be recommendable. On the contrary, I consider Cæsarean section as practised by Halbertsma and Kaltenbach—the requirements of V. Herff being fulfilled—as both a justifiable and valuable procedure. The requirements of V. Herff are to the effect that if the child is still alive in a severe case of eclampsia, and a natural birth is impossible, or the dilatation of the cervix is delayed, then the operation is justifiable. Now, when the mortality of the operation has been so greatly reduced, a successful result is very possible.—From article by Dr. Olshausen, of Berlin, in *Medical and Surgical Reporter*, July 9, 1892.

SOME THOUGHT STIMULANTS.

We may well extract a few paragraphs from a very suggestive article, by Dr.

Lauder-Brunton, in the *Lancet*, July 2, 1892, on "Posture and its Indications." He says:

In cases where the circulation is exceedingly weak and syncope is threatened, a most useful plan is to make the patient put his head down between his knees, so that an ample supply of blood shall reach the cerebral centres. Long ago, before the introduction of anæsthetics, a common plan of rendering patients senseless previously to the performance of an operation was to lay the patient flat upon his back and then suddenly hoist him to a standing posture by six strong men who held him by the arms, three on one side and three on the other. The brain being thus, as it were, lifted away from the blood, became so anæmic that it ceased to act until the circulation could adapt itself to the new posture.

An experience of my own once showed me how very dependent the brain is upon the supply of blood. I was called upon one night after a long day's work to write an article immediately. I sat down with pen, ink and paper before me, but not a single idea came into my head, not a single word could I write. Lying back I soliloquized: "The brain is the same as it was yesterday and it worked then, why will it not work to-day?" Then it occurred to me that the day before I was not so tired and probably the circulation was a little brisker than to-day. I next thought of various experiments on the connection between cerebral circulation and mental activity and I concluded that if the blood would not come to the brain the best thing would be to bring the brain down to the blood. I laid my head flat upon the table and at once my ideas began to flow and my pen began to run across the paper. I thought "I am getting on so well I may sit up now," but the moment I raised my head my mind became an utter blank, so I put my head down again flat upon the table and finished my article in that position.

Stimulation of some branch or other of the fifth nerve seems to increase the circulation in the brain, and those who are making their utmost call upon their mental powers are accustumed to stimulate this nerve in one way or another. The late Lord Derby used to eat brandied cherries, and an experiment of Marey's proves that mastication will accelerate the flow of blood through the carotid artery, and serves to show the wisdom of an editor whom I knew who used to eat figs while writing a leading article, and even of those who indulge in the practice so disagreeable to their neighbors of chewing tobacco. Others stimulate the gustatory branches of the fifth nerve by the sweets which they suck or by the smoke of a cigar or cigarette; while a rustic called upon suddenly to answer a question will probably excite the cutaneous branches of this nerve by scratching his head, and a man of more culture may stroke his mustache or beard, press his forehead or eyes, or, like many Germans, smite his nose with the forefinger.

A similar reason may be given to explain the habit of snuffing formerly so much in vogue. The gentle titillation of the nasal mucous membrane by the snuff probably serves to stimulate the cerebral circulation and the increased arterial tension due to the efforts of sneezing so increases the cerebral nutrition that difficulties seem at once to disappear and obscurities of mental vision are so rapidly removed that snuff is said in popular language to "clear the head." The practice of snuffing has fallen to a great extent in disuse, but it may still be occasionally employed with advantage in cases of severe and persistent headache where other remedies fail to relieve. Even where such a strong irritant as snuff is not resorted to, smelling salts (sal volatile) or aromatic vinegar may give considerable relief in headache if frequently inhaled.

While stimulation of the fifth nerve as just described tends to keep people awake and increase their mental activity, gentle, rhythmical stroking of the head

tends, on the contrary, to make them fall asleep, and brushing the hair has this effect on many people to such an extent that the movements of the hairdresser's fingers over the scalp and rhythmical click of the shears will send some people to sleep, even at the risk of having their hair shorn to a much greater extent than would be at all pleasing to them on awakening. A gentle rubbing of the scalp, as if to loosen it upon the skull, also tends not only to sooth irritability, but to relieve and to prevent headaches.

Recommendations of Therapeutic Agents.

Modern surgery has been fortunate in many of the newer agents it has added to its resources, and among these aristol must be cited as the most notable. It is difficult to realize, to-day, that previously to the discovery of aristol there was hardly a general laboratory in America or Europe in which experimenters were not constantly employed in seeking for a suitable substitute for iodoform, while it was hardly possible to take up a medical journal without reading of some new (and always inadequate) method of masking the awful odor of that surgical abomination. Now we rarely meet with these recipes, and all surgeons know the value of aristol. Surgery waited long for this topical remedy, but its splendid qualities redeemed its tardiness. The absence of offensive and toxic properties united in its healing qualities were fully sufficient of themselves to make a great reputation for aristol. But its value as a dressing was still more highly appreciated when it found that it would adhere closely to denuded surfaces and make an impervious coating over them. Ulcerated areas which had defied the classical applications quickly closed under the stimulating influence of aristol, and in many gynæcological cases in which iodoform was inadmissable aristol did the work promptly and effectually. In burns, scalds, bed-sores and as a dressing for blisters, aristol is the most eligible application, and it is indicated in all of the operations of minor surgery. It has been successfully used, also, in diseased conditions of the eye, ear and nose, while in rectal surgery it is recognized as having special value. In major operations its superiority over iodoform is specially marked on account of its freedom from toxic influences; and in abdominal surgery aristol has no superior. Dental surgeons, also, have given it their unqualified approval. Indeed, the range of aristol has become so widened that it is regarded rather as the superior of than a substitute for that once useful but malodorous remedy, iodoform.

Medical Items.

The following points were recently decided in a California case: A physician called by a man to attend a woman, supposed to be his wife, can recover for his services from the person summoning him, although the parties are not, in fact, legally married. One who calls a physician to attend a person whom he represents to be his wife is estopped to deny that fact in an action for his services rendered on the faith of such representation.—*Columbus Medical Journal.*

Dr. Novotny warns against the use of vaseline as a lubricator for sounds and other instruments introduced into the bladder, as he has twice found this insoluble vaseline serving as a nidus about which a mass of detritus had collected, and giving opportunity for the deposit of urinary sediments. In one case the quantity of detritus thus massed together upon a quantity of vaseline weighed ten grammes.—*Memorabilien.*

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CONTENTS

ORIGINAL ARTICLES.

Prophylactic Therapeutics as Applied to Tubercular Sputum. By Frank Dyer Sanger, M. D., Baltimore. 837

Linear Craniotomy for Defective Mental Development. By Wm. H. Morrison, M. D., Holmesburg, Pa. 843

SOCIETY REPORTS.

Clinical Society of Maryland. Stated Meeting held May 6th, 1892. Injuries to the Vaginal Outlet. Cranial Deformity and Optic Nerve Atrophy. Rapidly Growing Intra-Thoracic Tumor. 846

EDITORIAL.

Laboratory Therapeutics. 849

MEDICAL PROGRESS.

Fatal Result of Water Drinking.—Some Points Concerning General Paralysis.—Asthma from Rectal Trouble.—Bruises of the Brain.—The Abortive Treatment of Pneumonia by Large Doses of Digitalis.—Primary Laryngeal Croup.—Relapse of Typhoid Fever.—Treatment of Fevers.—The Simulation of Glycosuria by Asparagus in the Urine.—On the Methods of Operation in Carcinoma of the Rectum and their Results. 851

Original Articles.

PROPHYLACTIC THERAPEUTICS AS APPLIED TO TUBERCULAR SPUTUM.*

BY FRANK DYER SANGER, M. D., BALTIMORE.

Among some cuniform inscriptions of Western Asia, containing a number of formula of deprecatory incantations against the action of evil spirits, simultaneously published by Sir Henry Rawlingson and Mr. Edwin Norris, the following is found: "The expectoration of the consumptive which noxiously prostrates, Spirit of heaven, conjure it; Spirit of earth, conjure it."

The superstition entertained by the Chaldeans many centuries before the Christian Era has been resolved, in the process of time, into the scientific fact of the specificity of Koch's bacillus; yet we, of the nineteenth century, do not seem to be much in advance of the Assyrian astrologers; for, although scientific knowledge has replaced blind superstition, we do not seem to have been profited thereby. Certainly we have utterly failed to appreciate the teachings of modern research upon the causation of tubercular affections, if we have not at least learned the important lesson of prophylaxis, and recent experience has demonstrated the absurdity and futility of losing sight of the immediate practical bearing of scientific investigation while we wait in expectant inaction the evolution of its ulterior object.

It has been established that tuberculosis is an infectious disease, and that the infectious principle is the tubercle bacillus; that the discharges of infected individuals (the sputum chiefly) contain the bacilli in great numbers, and that these

*Read at the 743rd meeting of the Medical and Surgical Society of Baltimore, May 26th, 1892.

discharges are the means by which the disease is communicated from individual to individual. And yet there does not seem to be a disposition on the part of the profession in this country to make a practical application of these facts. Hardly any attention has been paid to the subject by American writers, and we have only to look about our hospitals and talk with the general practitioner to be convinced that the subject is scarcely thought of. When we consider the fact that fully one-eighth the mortality of the human family is due to tuberculosis in connection with the facts that the disease is infectious, and certainly to some extent preventable, the importance of the subject becomes evident. Granting that the sputum of tubercular individuals is dangerous, how can it best be disposed of, and what precautions should be observed in order to more effectually protect the well, and limit the spread of the disease?

There are two important factors in the destruction of tubercular sputum. In the first place, the sputum must be deposited in receptacles constructed with a view to disinfection; and secondly, it must be subjected to such processes or conditions as will insure destruction of the bacilli.

I. *Chemical Disinfection.*—Cornet does not directly condemn the use of chemicals, but he has pointed out the inefficacy of the common germicides, notably carbolic acid and bichloride of mercury. Corrosive sublimate is especially inefficient on account of the albuminoids contained in the sputum.

The newer antiseptics—lysol, creolin and aseptol—have been found wanting by Spengler and Schottelius. Even if some of these chemicals should be found to be efficient, their cost would make them impracticable for general use; their poisonous properties would also be an objection to their use in the family. We find in heat, however, a cheap, simple, efficacious and available means of disinfection.

It has been demonstrated that the boiling point (212° F.) is a sufficient degree of heat to kill the bacilli in a short time. As heat, or the means of producing it, are to be found not only in hospitals but also in the home, factory, public building, or wherever people habitually congregate, it is unquestionably the readiest means of accomplishing our end. The equipment requisite consists simply of a suitable spit-cup for the reception of the sputum, and a sterilizer. There are a number of designs of spit-cup on the market at present, and many schemes for destroying the sputum have been advocated. One of the most unique methods has been described by a writer in one of the numbers of *The Medical News*. He recommends that "the patient should expectorate upon pieces of newspaper, which, upon receiving the sputum, are twisted and dropped into a receiver, which should be emptied every two or three hours into the fire: or the papers may be *immediately* dropped into the fire." Still more filthy and dangerous are the rags recently advocated by the Board of Health of one of our large cities. The pasteboard and paper receptacles manufactured expressly for the purpose, which are in some of our hospitals, are not free from objection. The advantage claimed for them is that they are used once and then burned. Those that I have seen (and I have examined all the samples of spit-cup that I could obtain) have a standard or rack, which is apt to become filthy, and unless disinfected is a source of danger. They, therefore, have no advantage over glass or vitrified or agate ware cups, while there is the objection that they must be renewed at some expense.

Two years ago I became very much interested in the subject of sputum disinfection, and with a view to steam sterilization, gave the spit-cup question considerable study. After experimenting with a number of different materials, I

hit upon the agate iron ware, and had cups made of that material for Bay View Asylum. I have a cup here which I will pass around. The cup is, as you see, broad at the bottom so it cannot be easily upset; broad also at the top, and constricted above its centre, being similar to an ordinary cuspidor in shape. It has a handle so that it can be easily raised when the patient is reclining; it presents without and within perfectly smooth non-absorptive surfaces, and is sufficiently small to be carried should the patient leave his bed. A plain cover is an important feature of the cup, since, as Cornet suggests, it prevents the distribution of bacilli by flies, insects, etc. It also gives the cup a more cleanly appearance. Nothing is, it seems to me, more unsightly than an open sputum receptacle at the bedside. The plan for disinfecting these cups and their contents, which I devised at that time for Bay View Asylum, and which was adopted by the management of that institution, though it has not as yet been put in operation, consists simply of a wooden box lined with zinc, and sufficiently fortified to bear a boiler pressure of from ten to twenty pounds of steam. The cups with their contents are to be placed in this chamber on perforated shelves, and a connection made with the exhaust of the steam engine used for heating the buildings; the steam being introduced through a number of small jets from all sides immediately under the cover of the chamber: the bottom of the chamber slopes from all sides toward the centre, where a drain-pipe communicates directly with the sewer. A convenient water-tap makes the chamber not only a complete sterilizer, but a sink as well, where the cups, having been sterilized, can be cleansed before returning to the ward.

Not only can the boiling point (212.8°F.) be reached in this chamber (which will kill the bacilli after a few minutes contact), but a "boiler pressure" of 10 or 20 pounds of steam can be easily obtained, if desired, with a corresponding temperature of from 241° to 260.9° F.

This scheme for sterilization which I first described in a thesis on "Prophylactic Therapeutics as Applied to Tubercular Infection" submitted to the Alumni Association of the College of Physicians and Surgeons, Baltimore, two years ago, has been so thoroughly sustained by some recent exhaustive investigations upon the subject of steam sterilization made by Frosch and Clarenbach, and published in the *Zeitschrift fur Hygiene*, that perhaps I may be excused for quoting their conclusions at some length.

Conclusions:

I. The form and size of the disinfecting chamber have no effect upon the rate of penetration of the steam. In all disinfecting chambers the distribution of temperature through all its parts is homogeneous; dead spaces do not exist.

II. The velocity with which the steam is introduced into the apparatus is of significance only so far as it hastens the filling of the chamber. When the chamber is once filled it is then only necessary to admit enough steam to replace that which is condensed during passage through the apparatus and its contents. From an economical standpoint it is well to reduce the amount of condensation by encasing the apparatus in some non-conducting medium.

III. The rate of penetration of steam into objects to be disinfected is slower when directed from below, upward, than when from above, downward. It is therefore better to admit the steam to the chamber at the highest, and release it at the lowest point.

IV. The rate of penetration of steam is not affected by the volume of objects in the disinfecting chamber. It is therefore economical always to fill the chamber to its fullest extent.

V. With steam under slight tension, the desired temperature of 100°C. is more quickly reached than when simple steaming is employed. The pressure need not exceed one-twentieth or one-tenth of an atmosphere. With small objects, however, such as bandages, dressings, etc., the excess of pressure is hardly necessary. Without it the process is less costly, less dangerous and just as effectual. For the disinfection of large objects, however, it is advisable to employ steam under slight tension.

It will be seen that every requirement of thorough disinfection is fulfilled by the above described apparatus, the only expense being the cost of the chamber, which is trivial, the steam used being the exhaust from the steam engine which is in constant use. A sterilizer of this description meets the requirements of large institutions, railroad terminals, public buildings, factories, etc.

In smaller hospitals a modification of the plan, or an ordinary Arnold tin or copper sterilizer and a Bunsen lamp can be provided. In the dwelling a kettle of boiling water answers the purpose.

The nature of tuberculosis is such that a large number of infected persons are not confined to their homes, nor are in our hospitals; but from choice, more often from dire necessity, they mingle with their fellows in almost every avocation of life. Not only are they in places of business, but they also attend our churches and schools, our theatres and other places of amusement. They travel in every conveyance and mingle with the well wherever people habitually congregate. It becomes evident, therefore, that a modification of the principles advocated for the care of sputum in hospitals and the home must find a more universal application.

Provision should be made in every public building, factory and conveyance for the reception and disinfection of the expectoration of infected persons. Not only should such provision be made by law, but a competent sanitary inspection under a Governmental Health Department, which would include a bureau of disinfection in every considerable town, should see that these laws are executed.

In one of our Western States a step in the right direction has been taken, and the owners or managers of railway coaches and street cars are required to provide spittoons containing a bichloride solution for passengers who cough and expectorate. Similar provision should be made for all public places, and especially in those places (factories etc.) where a large number of people work a number of consecutive hours in a circumscribed air space.

Indoor occupation has alway been considered an important etiological factor in tuberculosis.

Insufficient fresh air and insufficient muscular exercise are undoubtedly very important predisposing factors, since they diminish the resistance of the individual, but they are not of themselves a direct menace to life. The dusty occupations which have been considered so dangerous are so probably in this way: the dust particles act as irritants to the air passages, and at the same time carry bacilli to more or less inflamed mucous membranes. Inorganic dust material is comparatively harmless.

The chief danger which threatens the vast army of people who are forced to work indoors, and who contribute largely to our mortality from tuberculosis, does not reside in the fact of their indoor occupation, or in the nature of their occupation, alone; but in the fact that from poverty many men and women, though suffering from tuberculosis in more or less advanced stages, are forced to occupy their positions where their expectoration, deposited upon the floor, soon becomes a part of the dust-laden atmosphere, to be breathed by their unfortunate associates.

I would like just here to commend a law recently enacted by one of our State Legislatures, fixing the minimum individual air space in factories, work-shops, etc. Too little attention is paid to the air space and ventilation as well as the other sanitary conditions of the places where the great masses of humanity spend nearly half of their existence laboring for the few. In the open air people must expectorate upon the ground; however, the danger of infection is not comparable with that which exists in a confined air space.

Cornet has shown that the hygroscopic character of sputum is opposed to its complete desiccation. The occasional rains and the frequent artificial wetting of the streets, therefore, prevent the bacilli from getting into the atmosphere. Those which do find their way into the atmosphere are dissipated by the freely moving air currents. There is, however, another danger which should not remain unmentioned, though I shrink from antagonizing a foe so formidable and unconscionable as fashion. Still the present fashion of wearing a train on the street is so filthy that it should be denounced by all persons to whom the cause of cleanliness is dear.

There is no material constantly found on the streets of our cities more apt (because of its vicious character) to become attached to a trailing train, than tenacious sputum which, with an abundance of other minor filth, is carried into the home, to be brushed off when dry, and become a part of the air of the dressing room or sleeping apartment.

If scrupulous cleanliness regarding the sputa of infected individuals is of such great importance in preventing the spread of the disease, since the means of disinfection are so simple and available, what yet remains necessary to the inauguration of the reform? *Simply that people be made to understand its importance*: they will then co-operate. As Professor Tyndal says in his admirable résumé of Cornet's work in the *Fortnightly Review*, "The public must make common cause with the physician."

If tuberculosis is a communicable disease, and the means of preventing such communication are known, such facts should be in the possession of the public at large. It might with equal propriety be argued that the contagiousness of small-pox and the virtues of vaccination should never have been disclosed to the world, as to hold that people should not be enlightened upon the subject of the contagiousness of tuberculosis and the means of its prevention so far as they are known.

If people are told that "consumption" is not contagious in the popular sense of the term, but it is communicated from individual to individual by means of the sputum chiefly, and can be made to understand how this takes place, if they are shown how this can be prevented and the importance of so doing, much will have been accomplished.

"The fear of spreading panic among the community . . . must be dismissed," says Mr. Tyndall.

Let every infected individual understand that a thorough disinfection of his own sputum not only adds materially to his chances of recovery, but also to the safety of his friends and those about him; that the only safe repository for his sputum is in some vessel or cup which can be boiled or otherwise subjected to heat; that he must not expectorate upon the floor, carpet or bed covering; that his handkerchief is an especially dangerous receptacle; a beard is also objectionable inasmuch as it is apt to become soiled with the expectorated material.

Teach the relatives, friends, or whoever have the care of the tubercular individuals, the same lesson of scrupulous cleanliness so far as the sputum is concerned;

that the discharges from the bowels should also be disinfected if the patient has diarrhœa; that they should not sleep in the same room with an infected person; nor use the same knives, forks, spoons, etc., if it can be avoided; in any case, such articles should be boiled. The laundry of consumptive persons should be boiled before going to the general wash, if it can not be done separately.

Teach free ventilation, for dispersion of the bacilli which may yet find their way into the respirable air of rooms, even when strict precautions are taken, greatly militates against the possibility of infection.

The apartments occupied by tubercular patients should be frequently cleansed and disinfected. Do not permit tubercular mothers to nurse their offspring; nor should infected persons be allowed to kiss the well.

Infected mothers should as far as possible entrust the care of their children to the well; hence the necessity of great care in the selection of nurses and servants.

All precautions which interfere with the intimate relations between members of the family must be annoying, if not positively odious, to most people; but if the facts are stated unreservedly and without circumlocution, few will be found unwilling to acquiesce. How many mothers are there who will not make any sacrifice requisite to the welfare of their children?

In hospitals the requirements of thorough disinfection are easily met. In those institutions where many tubercular cases are treated, the question of isolation of such cases naturally arises. I believe, so far as it is practicable, it should be done; for while the necessity of isolation diminishes in proportion to the degree of cleanliness, still the safety of persons whose lungs have been injured by previous disease would be more absolute if tubercular patients were treated in separate wards.

In large hospitals grouping of patients is desirable; then, too, the persistent cough of the consumptive patient, especially at night, is objectionable in the general ward.

A feeble attempt was made by Dr. Haines and myself to keep tuberculous cases together in the hospital department of Bay View Asylum; but the arrangement of the wards is such that it is impossible to separate the cases properly.

However, one ward has been maintained in that institution for the past two years in which none but tubercular patients are treated. This is, I believe, the first attempt that has been made in Baltimore to carry out what will some day become universal practice.

The treatment of tubercular patients in Sanitaria, especially adapted for the work, is no longer an experiment in this country. One has only to familiarize himself with the work accomplished at Saranac Lake, N. Y., at Asheville, N. C., at Colorado Springs, and by a camping-out organization, the headquarters of which is at Santa Fe, New Mexico, to be convinced of the beneficence of these institutions. They are not, however, for the poor.

The establishment of co-operative farm schemes, near our large cities, where infected individuals may be supported or given the opportunity of self-support, which will not only be a direct benefit to the individual, but will obviate the necessity of his working in crowded factories, shops and counting-rooms, and thus endangering his associates, belongs, I believe, to the philanthropy and progress of the near future.

To Dr. Edward O. Shakespeare much credit is due for his able appeal to the Association of American Physicians; in a paper read before that body, May, 1890, he says: "Do we not admit that tuberculosis is an infectious disease? Then let us so declare. Do we believe that this disease rarely, if ever, has a

truly hereditary origin? Then let us not hestitate to publish that belief. Do we acknowledge that the tuberculous, especially in the active stages of the affection, throw off in the sputa or in other discharges the infectious principle of the disease, and thereby jeopardize, whether little or much, the safety of the healthy? Then let us boldly publish our knowledge, for the benefit of the public who are not in possession of it. Are we convinced that the meat and milk of tuberculous animals often contain the infectious poison and produce the disease in the healthy consumer? Then let us without further delay strenuously and unitedly demand the vigorous inspection of the meat and milk supply, and prompt destruction of affected animals. Do we agree that habitations become infected with virulent sputum from the consumptive and constitute a danger to other inmates? Then let us insist upon thorough disinfection and immediate destruction of that dangerous matter. Is it probable that an injured condition of the lungs or of other exposed organs increases the risk of development of tuberculosis after exposure to the infection? Then let us prevent many a case of consumption by insisting upon the removal of phthisical patients from the general medical wards of hospitals. Are we convinced that the unfortunate subject of tuberculosis constitutes a migrating centre of possible infection? Then let us warmly advocate the establishment of special consumption hospitals."

One of the highest functions of the medical profession is the education of the public upon the great question of sanitation. We have no institute of preventive medicine, our Government giving us no financial encouragement, but the medical profession of this country constitutes a working body, for whose indomitable energy and untiring industry the task of eradicating tuberculosis from the face of the earth is not too great.

"Should the sources of infection be only partially removed," says Mr. Tyndall, "the marked diminution of a malady, which now destroys more human beings than all other infectious diseases taken together, will, as pointed out by Cornet, be our exceeding great reward."

18 West Franklin Street.

LINEAR CRANIOTOMY FOR DEFECTIVE MENTAL DEVELOPMENT.*

BY WILLIAM U. MORRISON, M. D., HOLMESBURG, PA.

Linear craniotomy is an operation suggested some two years ago by Lannelongue,† of France, as possibly of service in certain cases of microcephalus and deficient mental development. In the case now reported thirteen months have elapsed since the operation, and the child certainly shows a decided improvement in its mental and physical condition.

The subject of the report, M. L., male, was born August 30, 1888, and has now reached the age of three years and six months. The mother was a primipara. The head presented in an occipito-posterior position, the occiput rotating into the hollow of the sacrum. Forceps were applied and the child delivered. There was no apparent injury to the head, but in the course of a few days there formed, as a result of the pressure, a slough back of the left external angular process and one in front of the right ear. Whether or not this had anything to do with the development of mental defect, I am not prepared to say. When the child had reached the age of a few months, it became evident that its mental condition was not up to the average, and as it became older this mental deficiency

*Read before the Philadelphia County Medical Society, May 25, 1892.
†L'Union Medical, July 8, 1890.

became more observable, and the child presented every appearance of drifting into complete idiocy. In regard to family history, it may be said that the parents are young and healthy and there is no known tendency to mental disease or deficiency on either the paternal or the maternal side. Two children have since been born, and both are normal, mentally and physically.

In December, 1890, I suggested a trial of the operation of linear craniotomy, which had been brought forward a few months previously by Lannelongue. The suggestion was accepted but the performance of the operation was postponed for four months on account of the expected confinement of the mother. During this time the parents tried every means at their command to educate and improve the mind of the child, but no signs of betterment could be detected.

The operation was done April 17, 1891, thirteen months ago, and a report of it appeared in the New York *Medical Record*‡; I quote from this report an account of the child's condition at that time and of the steps of the operation.

"Age two years and five months; height, 32 inches; length of right leg, 15¾ inches; length of left leg, 15⅝ inches, a difference of ⅛ inch; circumference at middle of thighs, 8½ inches. The measurements of the head were: Occipito-frontal circumference, 18½ inches; semi-circumference from one external auditory meatus to the other, 12 inches; antero-posterior diameter, 6½ inches; biparietal diameter, 4¾ inches; bifrontal diameter, 3¾ inches.

"He is able to sit alone, but cannot stand. He moves from one place to another by sliding on his buttocks. There is some contraction of the gastrocnemii muscles, so that when he is supported on his feet the body is thrown backward. The grasp of the two hands is equal and strong. The right patellar reflex seems absent, the left normal. There is no apparent paresis or paralysis. He is unable to talk. He can utter a few words. 'Bert,' 'baby,' 'six,' and 'seven' is the extent of his vocabulary, and it is seldom that he can be induced to say even these words. He cannot understand what is said to him. His only means of indicating that he wants something is by crying, and it is only by offering him various articles that it can be determined what he wants. His attention can be gained with difficulty, and when gained can be held but for a moment. He does not show that he understands when his name is called. Almost every day he has, without apparent cause, spells of crying, without tears, which will continue for two or three hours. When pleased, he shows it by a broad, idiotic smile. He eats fairly well and is well nourished. There is no incontinence of bladder or bowels.

"*Operation.* The head was shaved and the usual antiseptic precautions were adopted. An incision was made through the scalp, beginning at the line of the hair, two inches above the superior edge of the left orbit and extending backward eight inches, parallel with the median line, and one inch distant from it. Bleeding was controlled by hemostatic forceps. During the early part of the operation a rubber tube was placed around the head to prevent bleeding, but it was found unnecessary and was laid aside. A one-half inch trephine was applied at the anterior extremity of the wound, its center being three-fourths of an inch from the median line, being so placed that the section in the bone would not correspond with the incision in the scalp. The button of bone removed was one-sixteenth of an inch in thickness. With the rongeur forceps, as modified by Dr. W. W. Keen, a strip of the skull three-eighths of an inch wide was removed, beginning at the trephine opening and extending backward seven inches, parallel with the median line, and half an inch from it. The dura mater ap-

‡July 18, 1891.

peared healthy, and was not markedly adherent. Bleeding from the bone stopped spontaneously and no ligatures were required for the scalp vessels. The wound was thoroughly cleansed and united by numerous silk sutures. A few strands of cat-gut were placed at each extremity of the wound for drainage and a moist bichloride dressing applied."

For a day or two following the operation there was some fever and signs of cerebral irritation. Removal of the dressing showed that the difficulty was due to the fact that the posterior extremity of the wound was occluded, the catgut failing to act as a drain. The catgut was then removed and a short rubber drainage-tube substituted. Following this the recovery was uninterrupted, all parts of the incision, save the posterior extremity, uniting by first intention. Two weeks after the operation the wound was completely healed.

As soon as the patient had recovered from the direct effects of the operation, it became evident that there was a change in his mental condition. His attention could be engaged readily and he would follow the speaker with his eyes. Within a few weeks he was able to indicate food and drink by pointing toward the desired object, and began to pick up new words. The mental improvement has been continuous.

May 22, 1892, the condition is as follows: Age three years and six months; height, 37¾ inches, a gain of 5¾ inches; length of the right leg, 17¼ inches; length of left leg, 16¾ inches, a gain of 1½ inches; circumference at middle of right thigh, 11 inches; of left thigh, 10½ inches, a gain of 2 inches. The measurements of the head are, occipito-frontal circumferences, 19 inches, a gain of ½ inch; semi-circumference from one external auditory meatus to the other, 13 inches, a gain of 1 inch; antero-posterior diameter, 6¾ inches, a gain of ¼ inch; biparietal diameter, 5 inches, a gain of ¼ inch; bifrontal diameter, 3½ inches, no gain. The incision through the bone, which was made three-eighths of an inch in width, is now not more than one-eighth of an inch in width. In studying the measurements of the head, it will be seen that while all the dimensions have been increased, the greatest gain has been in the semi-circumference from one auditory meatus to the other, amounting to one inch. As the bianricular line represents two thirds of the circumference of the skull at this point, an increase of one inch in the length of this line would correspond to an increase of about one-half inch in the diameter, but as the biparietal diameter shows an increase of only one-fourth of an inch, it appears clear that the skull has expanded more vertically than laterally.

While the nutrition of the muscles of the lower extremities has improved, there is still decided want of development. He climbs up by chairs, and stands indefinitely. He will follow the chair as it is moved and will walk if supported by the hand, but his gait is very unsteady. He can stand alone and has done so for half a minute at a time, but is in great fear of falling. He has been found half way up a steep stairway. He listens attentively when spoken to and seems to understand what is said to him. He protrudes his tongue or offers his hand when asked. When lying down, if told to get up, he does so. He knows what he wants and asks for it. He has acquired many words and puts them together intelligently in short phrases and sentences. On parting, he waves his hand and says "Good-bye." He plays with other children and seems to enjoy himself. The annoying, unmeaning crying spells, which were of daily occurrence prior to the operation, have not since occurred.

It is certain that in this case the operation has been followed by decided improvement in the mental condition. The question, of course, arises whether

this is the result of the operation or simply a sequence. Although I approached the operation with considerable scepticism, I believe that the change noted is the direct result of the operative procedure, and the principal reason for this view is, that for four months after the operation was decided upon, the child was kept under observation and every effort made to improve it by education. At the end of that time there was no apparent change: but within a few months, and, in fact, a few weeks after the operation, the other conditions remaining the same, there was a distinct and positive improvement. It, therefore, seems fair to assume that the operation was the cause of the change. I do not mean to claim that this operation will be followed by benefit in all cases. I simply report the facts as I find them in this instance. It may be that the operation is not indicated in many cases of defective mental development, for, as I have said in the article already referred to: "It does not seem logical to suppose that this procedure will benefit a large proportion of these cases, for in many of them there is probably more than a relative disproportion between the development of the brain and its bony covering; but, even if a small number be reclaimed from utter idiocy and be permitted even a moderate intellectual development, it is so much gained, and would justify a procedure attended with much greater risk to life than is linear craniotomy."

This matter has been studied, particularly from a neurological standpoint, by Dr. M. Allen Starr, of New York. In a recent paper§ he takes the same view as that just expressed. He says: "Hemiplegia, sensory defects, and imbecility occurring with or without epilepsy in children, are chronic diseases incurable by medical treatment. Any means which may be legitimately used to save the individual from a life of invalidism and to take the burden of his care from the family is to be employed." Dr. Starr has collected reports of twenty-five cases, eighteen of which, including two of his own, were operated on in this country. Of this number, seven died within a short time after operation. In the remaining eleven cases improvement is noted, but the period at which the reports have been made has been too short to warrant any definite deductions. The determination of the value of linear craniotomy is still a question for the future.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD THURSDAY, MAY 6, 1892.

The 266th regular meeting was called to order by the President, Dr. Robert W. Johnson.

Dr. Geo. H. Everhart was elected to membership.

Dr. Howard A. Kelly introduced to the Society Dr. Weigert, of the Rotunda Hospital, Dublin. Dr. Weigert was invited to take part in the proceedings.

Dr. H. A. Kelly then spoke on INJURIES TO THE VAGINAL OUTLET, illustrating his remarks by many beautifully prepared photographs thrown upon a screen by a stereopticon. The photographs were all taken from cases under Dr. Kelly's care, both in Philadelphia and in the Johns Hopkins Hospital, Baltimore, and illustrated the operating room, normal vaginal outlets, injured outlets of different kinds, and the various steps in the operation for restoration. Dr. Kelly said in part: Injuries to the vaginal outlet are of three sorts: First, involving the *exter-*

§New York Medical Record, January 23, 1892.

nal anterior part of the perineum, that is, the tissue from the fourchette backwards toward the anus and upward toward the vagina. This is a superficial tear of no serious moment. The second form is the *complete tear* involving the whole of the recto-vaginal septum. Here the sphincter is ruptured and as a consequence the patient is unable to control her bowels or gases. The fact that a prolapsus is so rarely associated with this condition shows that the peritoneal body is not the supporting structure of the pelvic organs. The third form is the *internal tear*, that is, where the rupture lies in the right or left side of the vagina, or both, and can only be seen on drawing apart the labia and lifting up the anterior wall with the speculum. This tear is concealed and is rarely seen. It is, however, from its frequency and its effect the most important of all, for the result of such an injury is relaxation of the vaginal outlet. The rupture in the sulci extends down into the tissues separating the levator ani from its rectal attachments; the muscle is therefore no longer able to hold the rectum up under the pelvic arch; the anus drops backwards, the vaginal walls roll out, and often without any external injury whatever, or even with an external perineum larger than normal from its over-stretching. Extensive eversion of the vagina with decensus of the uterus is one of the sequences of the inside tear.

The operation for such an injury is section of the relaxation. There is no advantage in an operation that does not sacrifice any of the tissue; the best treatment is to take out of the relaxation just enough tissue to bring it back again to the normal size. It is not proper to confine this resection of the vaginal outlet to the exterior alone. The injury is more on the inside; and for this reason the operation is also made to extend up the vagina by making the denudation or resection in both the sulci and across the lower anterior face of the posterior vaginal wall. Two triangular areas of denudation point up both sulci; in these the tisses on either side are loosely approximated by means of a single silk-worm-gut suture to each sulcus. This is the tension suture. A number of cat-gut sutures are then able to do the work of approximation above this. (Cat gut must never be used where there is much tension). The lower part of the denudation is brought together by silk-worm-gut sutures passed in a transverse direction. An outlet thus restored appears perfectly normal or even virginal. If you were to examine such an outlet a year or two after the operation, you would say that the woman had an intact perineum.

Dr. J. Edwin Michael agreed with Dr. Kelly that the essence of this whole matter is the amount of damage inflicted upon the levator ani muscle. Sometimes a long perineum is a better indication of internal trouble than a torn perineum.

The operation referred to by Dr. Kelly, in which no tissue is lost, can hardly compare with the operation, which Dr. Kelly practises: it cannot take up the broken ends of the levator and tuck them up under the pubes, and that is what is wanted in these cases.

We are apt, in these cases, to do too much and to make the vaginal outlet too narrow. The point on the labium, at which the normal cleft ceases, is comparatively easily determined, and this enables us to give the proper size to the external opening; but in our internal denudations we are inclined to do much and produce too great narrowing.

I recently attended a patient in labor, who had previously had a tear repaired by the method which has been explained by Dr. Kelly. The new-made perineum withstood the trial of a second labor, and is now about as good as before the labor occurred.

We ought to be thankful to Dr. Kelly for taking advantage of the circum-

stances with which he is surrounded, and illustrating the subject in this vivid way.

Dr. J. H. Branham: The tear of the levator ani muscle may sometimes be extensive without any laceration of the mucous membrane; and, on the other hand, the mucous membrane may be extensively lacerated with very little laceration of the muscles. Nature, of course, attempts to repair these damages, but the general practitioner, in allowing his patient to move about and sit up too soon, thus allowing pressure from above on the torn muscles, interferes with the efforts of nature. The condition should be recognized, and the patient kept long enough in bed to permit of thorough repair.

Dr. Harry Friedenwald read a paper on CRANIAL DEFORMITY AND OPTIC NERVE ATROPHY.

Dr. G. J. Preston thought the nerve atrophy was due to certain inflammatory conditions of the meninges and special pressure, and not due to general intra-cranial pressure.

The operation of linear craniectomy has not been a success thus far. The operation gives an opportunity for brain expansion, but very little. The damage has usually been done before the operation is undertaken.

Dr. Friedenwald: In cases of tumors of the brain, which are found far away from the anterior part of the brain, optic neuritis follows, and it is very hard to account for it except on the theory of increased intra-cranial pressure, and my suggestion was that in cases of marked cranial deformity we are probably likely to have, at some period, a time when the intra-cranial pressure reaches the same height as it would in the case of intra-cranial tumor.

Dr. I. E. Atkinson narrated a case of RAPIDLY GROWING INTRA-THORACIC TUMOR, ending in death by suffocation in six weeks after first consulting his physician. The tumor, an aneurism of the innominate artery, was exhibited by Dr. K. B. Batchelor.

1519 N. Broadway. W. T. WATSON, M. D., Secretary.

PRECAUTIONS AGAINST CHOLERA AT EUROPEAN PORTS.

Great precautions are now being taken by the British officials, at all the various exposed points liable to be visited by cholera in 1892. By their request, and those of other European governments, the authorities of Egypt are said to be exercising an unusual vigilance to prevent an incursion of the disease. Their principal activity has been and will be exerted among the Red Sea ports. The route of most immediate danger to the European nations is believed to be by way of Arabia and the Suez canal. Reports from Aden leave no doubt that cholera has been prevalent at points contiguous to that line of travel. The disease is now epidemic in the interior of Arabia, and accounts are not wanting as to the ravages of the pestilence in that region. Hundreds have died daily from that cause; and the fugitives from the stricken districts, arriving at the seaports, state that at the town of Harrar alone, as many as 1,500 persons had died within a fortnight. Another route along which the disease may be expected to travel is that traversing India, Afghanistan and Asiatic Russia. It is reported that cholera is lurking in the latter region. This is a condition that is not publicly known, but has been confirmed by the announcement, made in official circles, that a special commission has been appointed from St. Petersburg to investigate the cholera question in the southeasterly provinces of the Empire. Along this line of traffic, Turkey and southern Russia are the countries primarily endangered by epidemic cholera.—*Journal of the American Medical Association.*

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BALTIMORE, JULY 23, 1892.

Editorial.

LABORATORY THERAPEUTICS.

We can all very well remember the slurs which were far from uncommon, with which the clinicians were wont to treat suggestions as to practical surgery coming from the laboratory, and we hear nowadays not unfrequently the same sort of remark bearing on possible therapeutic suggestions emanating from the same source. Let us remember, however, that, as we must now now admit, the laboratory has made modern surgery what it is and has transformed obstetrics, and has practically created modern hygiene, it is quite within the bounds of probability that it may transform therapeutics also. The tuberculin craze did much harm, not on account of the abuse of it by laboratory workers, but because it fell largely into the hands of the public which, like the Areopagites, is so fond of telling and hearing a new thing, and yet the result of the experience is not without valuable gain to the profession. Rational empiricism must in all probability still continue to be our guide in most of our therapeutic work: we must still give opium and its derivatives because we know by experience that it relieves pain; we must still use quinine for malarial diseases on empirical principles although the laboratory has taught us that it is because it exercises a deleterious effect on the plasmodium that it is efficient.

But there are certain indications which point to the coming of a much more scientific therapeutic management of actually existing disease, as well as of a power of prevention developed far beyond our most vivid dreams. Dr. Geo. M. Sternberg has given, in the July number of the *American Journal of the Medical Sciences*, under the title "Practical Results of Bacteriological Researches," a most valuable resumé of the laboratory work, which has already been in the direction of the production of immunity toward certain diseases, and one can scarcely read his valuable article without seeing in the future a most radical change in the management of at least a large number of the maladies which now afflict mankind. Vaccination is the *avant courier* in this direction, and when one con-

siders what a great boon it has been to humanity it is hard to understand how it has come about that work has been so slow in this direction. Pasteur's work in the direction of preventing certain diseases among domestic animals is too well known to require anything more than the briefest mention. His more important work in the prevention of rabies bears directly upon our subject. As is usual when great scientific advances are made there has been much abuse, opposition and misrepresentation, but when we see that among the latter statistics 416 patients, who had been bitten by dogs, *proved* to be rabid, and that *not one* of them developed the disease after having been treated, it seems to us that the time for scepticism has passed. This production of immunity from the use of attenuated virus is, however, not the latest and most valuable result of laboratory study.

The discovery of the *anti-toxines* seems to indicate the direction from which we are to expect most. Certain animals are naturally immune against certain diseases. Thus, rats are immune against anthrax, so also dogs and frogs. The blood of an immune animal injected into a susceptible one, say a mouse in the case of anthrax, renders it also immune, and subsequently inoculations of anthrax virus do not produce a fatal attack. Artificial immunity has also been produced against diphtheria and tetanus (Behring and Kitasato). These matters have, however, gone beyond the stage of laboratory experiments. Dr. Sternberg refers to six cases in which patients suffering with traumatic tetanus have been successfully treated by injections of the blood serum of a dog, which had been rendered "strongly immune" against that disease.

We have not the space at our disposal to give even an imperfect resumé of the work upon which Dr. Sternberg's paper is based, but we hope we have called sufficient attention to it to cause our readers whose daily work does not leave them time to follow up all these bacteriological researches to read it for themselves. The paper concludes with some interesting work done by the author in producing immunity in a calf against vacinnia by the use of the serum of a calf already made immune by vaccination.

The officers elected by the American Medical Association for the ensuing year are: Dr. Hunter McGuire, of Richmond, Va., President; Dr. H. O. Walker, of Detroit, First Vice-President; Dr. H. Brown, of Kentuckey, Second Vice-President; Dr. Jesse Hawes, of Colorado, Third Vice-President; Dr. R. J. Dunglison, of Philadelphia, Treasurer; Dr. W. B. Atkinson, of Philadelphia, Secretary; Dr. Montgomery, Assistant Secretary; Dr. Geo. W. Webster, of Chicago, Librarian. Milwaukee was chosen for the next meeting-place, although Chicago and Indianapolis were anxious for the honor. The following were elected to fill vacancies on the board of trustees of the association: Dr. Alonzo Garcelon, Lewiston, Me.; Dr. Leartus Connor, Detroit; Dr. Perry H. Millard, of Minnesota, and Dr. Patterson, of Washington. Members of the judicial council were selected as follows: Dr. John Norris, of Baltimore, Dr. H. D. Didima of New York; Dr. John B. Roberts, of Philadelphia; Dr. A. M. Emmert, of Iowa; Dr. W. T. Briggs, of Nashville, Tenn.; Dr. C. W. Vorhes, of Coldwater, Mich.; Dr. W. E. B. Davis, of Rome, Ga.; Dr. A. Morgan Cartlege, of Louisville; Dr. N. S. Davis, Chicago.

Medical Progress.

FATAL RESULT OF WATER DRINKING.

An old way of poisoning criminals used to be to compel them to swallow large quantities of bull's blood, and it is interesting to note how this acted as a means of causing death. Bull's blood is not a poison at all in the ordinary sense of the word, but when it enters the stomach it forms a coagulum, and instead of the organs being filled with liquid which might be ejected by vomiting, it is filled with a solid mass. This mass presses upwards upon the heart and displaces it. The pressure upwards upon the lungs interferes with the respiration and the pressure backwards upon the aorta, vena cava and the solar plexus would probably be sufficient to cause death. The same thing occurs in animals when they are first turned out among the clover; they over-eat themselves and are very likely to die from over-distension. A case was recently reported in the newspapers of an Irishman who had eaten largely of potatoes and milk and who died suddenly. The post-mortem examination revealed no disease. He was apparently healthy, except that his stomach was distended, and no doubt he died in exactly the same way as the criminals who were compelled to drink bull's blood. Generally death cannot be brought about by the simple drinking of fluids, because the stomach is able to eject them. Apparently, however, this is not always the case. In one of the lay papers a few days ago there was a notice of three Frenchmen who laid a wager as to who would drink the most water, and all three of them died in a comparatively short time. The death in this case might be partly due to the distension of the stomach and partly to the effect of the water on the blood after its absorption. It very rarely happens in a healthy person that enough water can be absorbed to cause any alteration in the blood, because it is excreted as rapidly as it is absorbed and the composition of the blood is kept nearly constant. Death from the action of water on the blood may occur after profuse hæmorrhage when thirst is extremely urgent. This has been noticed on the battlefield, and also in the case of women who have been nearly drained of blood by hæmorrhage. In these cases it is always advisable not to give pure water to quench the thirst, for it is not only an irritant to living tissue, but it is also destructive to the blood. The risk of injury is considerably lessened by adding a little salt to the water, making it of the strength of the physiological normal saline solution.—*Lancet.*

SOME POINTS CONCERNING GENERAL PARALYSIS.

At a recent session of the Ohio Medical Society, Dr. Zenner presented a paper (*Nashville Jour. Med. and Surg.*) upon this important but obscure subject.

After the mention of work and worry and syphilis as causes of the disease, a brief outline of the symptoms was given. The latter are gradual failure of the mental powers—attention, judgment, memory; the manifestation of delusions, especially delirium of grandeur; and motor symptoms, paresis of facial muscles, tremor of lips and tongue, a stammering speech, and often spinal paralysis. There are sometimes attacks of acute mania and paroxysms of an epileptic or apoplectic character. The average duration of the disease is three years. The earliest symptoms are most important to recognize, for if the disease be detected at an early period financial calamities may sometimes be averted, and it is only then that any thing could be hoped from treatment. Ordinarily the disease begins so insidiously that nothing is observed excepting by those coming most intimately in contact with the patient, and by them the changes are not attributed

to disease. The early changes are impairment of powers of attention, of judgment, of quick perception, of memory for recent occurrences, etc. The affections become less strong, though the patient may be emotional, cry easily, and the like. There is less attention paid to ordinary ceremonials, to matters of dress, table manners, etc., and the patient often becomes indecent in his actions.

There is usually some objective symptoms even at an early period, such as tremor of the lips and inequality of the pupils. Spinal myosis is a very important symptom. The union of the latter symptom and absent knee jerks had been seen in such cases by the writer.

The disease was often supposed to be ushered in abruptly with an attack of acute mania, when changes had taken place long prior to such an attack, but their significance had not been recognized. The writer then reported such a case, in which the condition of the pupils enabled him to make a correct diagnosis.

ASTHMA FROM RECTAL TROUBLE.

Giving, in an article upon this subject, his personal experience, Dr. Young (*Columbus Med. Jour.*, June, 1892) says: I had been a great sufferer from asthma for 22 years, and have been entirely cured. I was gradually becoming worse from year to year, always worse in the fall and winter, until last October. I had got down so low and seemed to have so little vitality left, that I despaired and thought I could not live through the winter. I was only a gaunted up, stooped-shouldered, gasping, wheezing invalid, with almost an incessant cough, spitting at least a pint of clear, tough, stringy mucus; I had to burn a stramonium remedy three to five times every night and several times during the day to get relief. My hands and feet were always cold, my digestion poor, had bilious spells or sick headache, every few weeks, and had alarming attacks of palpitation of the heart. All the flexor muscles of the body seemed contracted, so that I could not straighten out my fingers or throw back the shoulders. I had consulted hundreds of physicians, read everything on the subject that I could get, used all known remedies, and yet with it all I was still a hopeless invalid and had not learned what caused the disease. I had long thought that it was reflex and tried to find the cause, but owing to the fact that I was never conscious of local rectal symptoms, never mistrusted that the rectum was the seat of the trouble.

When my stomach was bad, and that was often, I tried by dieting and remedies to correct it. Then, again, I thought it was from nasal irritation, and had a specialist remove the pharyngeal tonsil and turbinated bodies, break down the septum and straighten it up, saw, bore, burn and spray throat and nose for months, and still had asthma all the time.

Rectal irritation as the cause of my asthma was never even hinted at until I consulted Dr. Pratt, and even when he assumed that to be the cause and wanted to examine, I demurred, saying that I had never had any rectal disease—no piles, pain, constipation or discomfort at all, and thought my bowels the best part of me. He asked if pregnant women vomiting in the morning complained of their uterus? I replied not necessarily, and he said so a man with asthma from rectal irritation would not necessarily complain of rectal symptoms. He examined, found what he predicted, and operated on me under an anæsthetic. I went to sleep during a bad attack of asthma and got awake without it, and have never had it since. I recovered from the operation in two weeks, and have kept right on improving every week since, until now I have gained twenty-six pounds; have never missed a meal or a night's sleep; my entire form and gait have changed, hands and feet are warm. I can straighten my fingers as far as

ever, and on waking stretch like a growing child: my step has become more elastic, and I have a buoyancy of spirits that I never had before.

BRUISES OF THE BRAIN.

In a lecture on "Bruises of Internal Organs" (*Lancet*, July 2), Sir William Savory says of bruises of the brain:

Bruises of the brain are, I believe, far more common than is usually supposed, and worthy of much more attention than they have hitherto received. In works on surgery contusion of the brain obtains a passing notice and occasionally, as at St. George's Hospital, a specimen to show contusion of the brain is to be found in our museums, but in practice it is for the most part included in the more vague and comprehensive condition of concussion. The relation of contusion to concussion of the brain presents some points of great interest. On what happens in a case of concussion pure and simple, we are not quite clear; certainly, we are not agreed, whether it be due to some sudden and temporary change in the minute vessels in the way of spasm, or whether—which I venture to think is more probable—it is due to some more subtle and profound molecular disturbance of the brain substance itself. As a matter of fact we know that cases of simple concussion severe enough to prove fatal are so very seldom seen that some even doubt whether they ever actually occur. That, however, concussion of itself, pure and simple, may prove fatal, and that more frequently, when death from injury of the brain is attributed to other causes it is really due to concussion I have no doubt, and the facts and arguments for this belief I have given elsewhere. So far, however, as the brain itself is concerned, the chief changes that are associated with severe concussion are contusion or bruising. In the worst instances this is accompanied by laceration of the brain substance and copious hæmorrhage, so that the blood collects in a distinct mass, but many cases occur, short of these, in which there is neither visible laceration nor blood-clots, but simply a bruised condition of the cerebral substance, and this perhaps in a situation opposite to the part struck. When in such an instance a section of the brain is made, the white or grey matter, as the case may be, exhibits a patch or patches, pink or red from bloodstain; and when these are more minutely examined, especially after water has been allowed to flow freely over the surface, numerous minute points or specks of blood appear scattered over the stained area. In these places the substance of the brain show the effects of bruising. There is here some rupture of substance and some extravasation of blood, but no visible laceration, and nothing which would be called hæmorrhage. There cannot, I think, be any reasonable doubt that this condition frequently occurs as the result of injury to the head short of any graver effect, and that such cases usually terminate in recovery. Under the head of concussion of the brain, cases are described in which recovery is not rapid and direct, but more prolonged and circuitous, in which the patient passes days and even weeks in a state of partial unconsciousness or constant drowsiness, with sometimes fits of restlessness, from which perhaps he may be temporarily aroused to make short replies to simple questions, but into which he immediately relapses when left to himself. Then, as consciousness is gradually restored, the mind remains in a dull and lethargic state, interference of any kind is often resented and the temper is sometimes strangely altered for the worse. Usually headache more or less severe is complained of. But the bodily functions in general in this stage are performed fairly well, and there is no fever or sign of serious disturbance in any other organ than the brain. In such cases many months often elapse before complete re

covery is assured, and during this period its progress is easily interrupted by any attempts to exert the mind. Patients in this state complain that they cannot attend to business, that they are incapable of sustained mental effort, that they have lost the power of self-control, that their senses of sight, hearing and taste are strangely disordered, and so on. Many such cases, in more recent times, have acquired interest of another kind from the fact that they have been the result of accidents on railways.

Now I am assserting that such a state as this, even in its more severe forms, may not be the result of what I have called simple concussion, that if the brain could be dissected any abnormal condition would be always visible, but seeing how different the effect of injury and the progress of the case are from that of many cases of what may be called simple concussion, even in its severe forms seeing this, and coupling it with the fact that bruises of the brain are not uncommonly seen when looked for after death from other causes, I think, to say the least, it is reasonable to assume that in such cases as I have alluded to we have to deal with the effects of contusion beyond those of concussion pure and simple.

THE ABORTIVE TREATMENT OF PNEUMONIA BY LARGE DOSES OF DIGITALIS.

During the past nine years Professor Petresco, of Bucharest, has relied entirely upon digitalis in the treatment of pneumonia. About a year ago he published the results by him in five hundred and seventy-seven cases.

In the *Bulletin général de thérapeutique* for February 15th he reports one hundred and seventy-eight additional cases. He states that he always uses a strong infusion of the leaves of the plant, from one to three drachms of the leaves being infused in eight ounces of water and simple syrup. Of this mixture a tablespoonful is given every hour during the day. In this way some of his patients took as much as one hundred and twenty grains of the leaves of digitalis in twenty-four hours.

The author alleges that these large doses abort the pulmonary process, as a rule, within three days. The fever and all the physical signs, both local and general, disappear as if by magic. A temperature registering 105° at the beginning of the illness drops to 96° or even 95°, and the pulse falls from 120 to 35 or 30 pulsations a minute. Not only was the duration of the disease shortened, but also the period of convalescence. All the author's patients found themselves in a state of perfect health within twenty-four hours after the "jugulation" of the pulmonary process. They could therefore at once take up their ordinary occupations.

The mortality of the disease was reduced to 1·22 per cent., and Dr. Petresco believes that it could be reduced to nothing if the digitalis were given in the doses mentioned in the very beginning of the pneumonia.

In not a single case were any phenomena of intoxication noticed. The more intense and grave the pulmonic process, the better were large doses, frequently repeated, borne by the patient.

In explanation of the favorable effect of digitalis in pneumonia, Dr. Petresco calls attention to the physiological action of the drug.

Digitalis stimulates the pneumogastric nerve, and the nerve in turn increases the contractile energy of the heart. The increased action of the heart forces on the blood current, and consequently prevents stasis of the blood if it has not yet occurred, and combats it if it has already taken place. Thus, even admitting the parasitic infectious nature of pneumonia, its treatment by digitalis, far from being contra-indicated, fulfills a pathogenic indication.

Digitalis is, however, not only a stimulator of the pneumogastric, but is also a vaso-constrictor. It therefore produces a current of flux and reflux of the blood, from the heart to the pulmonary capillaries and from the capillaries to the heart, thus preventing the congestion of the first stage and aiding the resolution and absorption of the exudation in the second stage of pneumonia.

The author insists that this double action of digitalis must be produced as quickly and as energetically as possible. This object is only attained by giving large doses from the beginning of the disease, instead of waiting for the cumulative action of the drug.

His principal conclusions are as follows:

1. Pneumonia can be aborted by digitalis in large doses given from the commencement of the malady.

2. This abortive treatment is the most rational, for it is based upon the pathogenic indication of pneumonia.

3. The value of this treatment is confirmed by the large number of cases already reported; the smallest mortality is observed in pneumonia treated in this manner.

4. The dose of sixty to one hundred and twenty grains a day of the leaves of digitalis in infusion is the proper therapeutic dose of digitalis in the pneumonia of adults; it is only from a dose of this amount that we have a right to expect immediate curative effects.

5. The tolerance and absence of toxicity of this therapeutic dose are proved incontestably by the statistics of the author referred to above.

PRIMARY LARYNGEAL CROUP.

E. Fraenkel (*Deut. med. Woch.*, June 16th, 1892) says that the presence of membrane in the fauces frequently extending to the larynx, trachea and bronchi is almost unanimously looked upon as true diphtheria, and as due to the Klebs-Loeffler bacillus, but that there is still some question as to the nature of a primary membranous laryngitis in which the fauces are intact. Four cases of this latter affection are here recorded, in which no membrane was found in the fauces by the author, either before or after death. In one of the cases the child was said by the parent to have had white patches in the throat a fortnight before the fatal illness, but there was no reason to believe that this was diphtheria. Pure cultures of the true diphtheria bacillus were obtained from the membrane in all these cases. Inoculation experiments upon guinea-pigs gave rise to the symptoms and pathological appearances usually produced by this bacillus. The animal rapidly fell ill, and soon died with paralytic symptoms. Double hydrothorax, hæmorrhagic swelling of both suprarenal bodies; and slightly hæmorrhagic œdema at the site of the injection were found. The author would conclude that idiopathic membranous laryngitis is etiologically identical with genuine faucial diphtheria. The presence of an enlarged spleen, of changes in the kidneys, and of swelling of the lymph follicles, especially in the ileum, found in these cases, is also in favor of this view. There are two other affections of the air passages which, in the author's opinion, require investigation, namely, the pseudo-membrane seen in the bronchioles in acute pneumonia and the bronchial casts of plastic bronchitis. In one case of fibrinous bronchitis from a fatal case of acute pneumonia the author found by cultivation and otherwise Fraenkel's pneumococcus in this exudation.—*Brit. Med. Jour.*

THE RELAPSE OF TYPHOID FEVER.

Discussing this phenomenon in the *Cincinnati Lancet-Clinic*, July 9, 1892, Dr. Murphy draws these practical conclusions:

1. No immunity to typhoid fever is given by one attack. Formerly it was held by some that the infiltration of the agminated glands, the solitary ones and those of Peyer, were destroyed by the necrosis and sloughing, thus creating an immunity to further inroad of the virus, or what is now called by many the bacilus of Eberth. This, however, is only theoretical.

2. The cause of the fever is by no means settled or ascertained.

3. While in this city its prevalance is greater in autumn, yet it is seen and treated more or less during every month of the year.

4. If the cause resides in the water, we should, according to our bacteriological friends, have the disease endemic in this city every month in the year.

5. Our friends who hold to the microbe theory of the disease may tell us, that while all those liable or predisposed to the disease—the young under thirty—may receive the microbe or bacillus in the polluted water or milk, yet that the great majority have so many phagocytes destructive to the typhoid bacilli, that they in this way escape the disease.

6. It is by no means demonstrated that typhoid fever is not produced by animal or organic decomposition. Time forbids me to dwell on this point.

7. The attempt to manage or cure the disease by remedies destructive of the bacilli is futile.

8. Active medication is forbidden by men of much clinical observation.

9. The main points in the therapy are to lessen the fever by the application of water to the surface, and cold water by enema, and to support the failing heart by stimulants, alcoholic in character, and by liquid food. At what temperature the water shall be applied, either by sponging, the pack, or the bath, is a matter of great judgment.

10. The coal tar antipyretics, antipyrin, antifebrine, and phenacetin, are depressants to the heart and should rarely be used.

11. Since the clinical thermometer has come into general use, and the danger of high temperature has been so strongly insisted on, there is reason to think that the use of antifebrifuges and antipyretics have done much harm, even to the production of death in cases otherwise mild, and which might have gotten well by the efforts of nature and abundance of liquid food. Certainly the large doses of quinine so much in vogue a few years ago did great harm.

12. Finally, in view of the possibility of a reinfection of additional glands taking place from ulcers slow in healing and open at the end of four weeks from the beginning of convalescence, it is well to insist on quietude and liquid diet for that time.

THE TREATMENT OF FEVERS.

The *Manchester Medical Chronicle*, for April, 1892, contains an article by Graham Steell, of Manchester, in which he reaches the following conclusions:

1. Attention must in all cases be directed to the normal fever of the disease and to the accompaning pulse-rate. Only when the fever and pulse-rate assume abnormal severity is there place for consideration of antipyretic treatment.

2. Of the methods of antipyretic treatment, that by bathing is unquestionably the best, and the patient should be placed, first of all, in tepid water, which is subsequently cooled. Wet packing is a much less efficacious method. Treatment by antipyretic drugs is the worst method of antipyretic treatment, but notwithstanding is often useful, both emplyed alone and as an adjunct to treatment by bathing. In hyperpyrexia, treatment by drugs is useless, and cold bathing affords the only trustworthy treatment.

3. The general laws which govern antipyretic treatment appear to be similar,

whatever the method of treatment adopted. He is aware that theoretical consideration may be urged against this statement, but he is speaking from the practical standpoint.

4. There can be no doubt that the severity of a fever in the immense majority of cases may be well estimated by the resistance which the pyrexia offers to antipyretic treatment. As a general rule, continuous fever offers greatest resistance, remittent less, and intermittent least. The greater efficacy of antipyretic treatment in the later stages of typhoid may be partly so explained. The fact of degrees of resistance to antipyretic treatment, corresponding to degrees of severity of the attack, suggests that the course of mild and moderate cases might be greatly shortened by a vigorous adoption of antipyretic treatment.

5. The difficulties in the carrying out of antipyretic treatment by bathing are so great that the treatment must be reserved in private practice for cases in which danger threatens from high fever and severity of the general symptoms. Antipyretic drugs may often be used with advantage as adjuncts to treatment by bathing, and occasionally alone. Nevertheless, their use is to be avoided as much as possible.—*Therapeutic Gazette.*

THE SIMULATION OF GLYCOSURIA BY ASPARAGUS IN THE URINE.

A very important note on this subject by Dr. Lisle appears in the *New York Medical Journal,* July 9th. A gentleman undergoing examination for life insurance passed urine of a light straw color, specific gravity 1.030. Upon applying successively, Trommer's, Fehling's and Boettger's tests, the urine responded to them all, thus indicating the presence of sugar; but upon fermenting a sample, not a trace of sugar was revealed. To harmonize these results, it became necessary to ascertain what was causing this unusual reaction. The only solution of the difficulty appeared to be in the fact that the gentleman had, on the day previous, eaten heartily of asparagus. To confirm this, on the day following, Dr. Lisle tested his own urine by the above mentioned tests (including fermentation), and no sugar was detected. He then ate a quantity of asparagus and tested his urine afterward every half hour. In about an hour and a half the urine possessed the peculiar odor so well known, and responded to all the tests mentioned, save fermentation. Twenty-four hours later a trace yet remained, but in forty-eight hours even that disappeared. He has repeated this experiment in eight cases with the same results. The light of these experiments leads the writer to this conclusion: That the ingestion of asparagus does *not* cause saccharinity of the urine, but something is formed and excreted which causes a response to the reagents used by physicians for detecting sugar; but by fermentation all doubt can be set aside.—*Med. Fortnightly.*

ON THE METHODS OF OPERATION IN CARCINOMA OF THE RECTUM AND THEIR RESULTS.

Schmidt (*Berliner Klinische Wochenscrift,* June 13, 1892) thinks that colostomy is of little value in carcinoma of the rectum, because it only gives temporary relief and leaves the cancerous tissue.

There have been several methods adopted.

1. The old operation of Lisfranc and Duffenback, dissecting the rectum and removing the diseased part.

2. The operation by osteoplastic resection of the sacrum, in order to lay the rectum open to a greater extent, and to have absolute control of the hæmorrhage.

The general condition of the patient must be the guide as to what operation is to be selected.

Carcinomas which are strongly attached to the surrounding tissue should not be operated upon.

Since the introduction of Kraske's method more radical operations are performed than in former years.

A contraindication to the radical operation would be the involvement of the bladder in the disease. Adhesions to the prostate or the vagina are not to be feared.

The Lisfranc operation consists in a circular incision; entrance into the pararectal space as far as possible from the diseased part; opening the peritoneum when it is necessary. The diseased portion of the gut is amputated, and the remaining part of the bowel is drawn down and fixed to the anus. Of fifteen cases operated on in this manner, in none has incontinence resulted. This operation is selected when the carcinoma is near the anus. The sacral operation is to be selected when the infiltration extends above the internal sphincter.

For this operation the patient is placed on the side and a long concave incision is made, beginning at the sacro-iliac symphysis, at which point the strongest adhesions are to be expected, and extending down to the tip of the coccyx, and finally circling about the anus. If the removal of the coccyx does not give sufficient room, as in many cases it does not, the pelvic ligaments are divided, and the sacrum is divided by means of a chisel in a somewhat oblique direction below the third sacral vertebra. If it be possible to save the pelvic ligaments on one side, it should be done, since less damage is inflicted on the floor of the pelvis, and the formation of a sacral hernia may be avoided. If the tumor should extend high up, the ligaments of the other side must be divided.

After the Douglas pouch is opened and the rectum freed, then with a continuous catgut suture the peritoneal opening is closed. Above and below the tumor to the extent of three centimeters an elastic ligature is placed about the bowel; the diseased mass is then removed between the ligatures and the continuity of the bowel completed by circular suture. For the circular suture the double row of Czerny is recommended.

In cases where the disease has been extensive, and a large portion of the bowel has been removed, requiring a great deal of tension to bring the ends of the bowel together, it is better to split the sphincter behind in the median line and suture each side separately to the proximal end of the bowel. As a result of this procedure the sphincter is for a time paralyzed until the muscle wound heals. This operation has been modified so that the sacrum is divided, and then after the operation sutured together again.

At times the piece of bone separated necroses, and must then by a secondary operation be removed.

By adopting antiseptic precautions Czerny's mortality was only four per cent., while other operators have had as high as fifty-three per cent. The mortality of the perineal operation was only 3.1 per cent.

Of the thirty-six sacral operations, only seven died.

The mortality of operations of all kinds for radical cure of sixty-eight cases was 11.7 per cent.

Of fifty-nine cases that left the hospital, twenty-five died in the course of six years. Twenty-eight still live, of which ten were perineal and eighteen sacral. The critical point of two years after the operation twelve cases have passed. —*Therapeutic Gazette.*

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CONTENTS

ORIGINAL ARTICLES.

The Treatment of Leg Ulcers. By Thomas S.K. Morton, M. D., Philadelphia. . . . 859

Trephining for Abscess of the Brain: Evacuation of Pus; Recovery. By Wm. H. Morrison, M. D., Holmesburg, Pa. 863

SOCIETY REPORTS.

American Health Resort Association. . . 867

EDITORIAL.

The Scope of the New Medical Law. . . 869

MEDICAL PROGRESS.

Treatment of Inebriety.—Treatment of Metrorrhagia.—Hay Fever.—Clinical College of Medicine and Specialty Hospital.—Skatalogical Medicine.—Your Vacation.—Warts and Porpoises.—Spray for Whooping-Cough.—Hereditary Transmission of Mutilations.—Rats Breed Disease.—"Golden Gems of Goodell."—Puerperal Insanity.—Dr. Munde on Chronic Salpingitis.—Duct Papilloma of Breast.—A Source of Danger Commonly Overlooked. . . 871

MEDICAL ITEMS. 879

Original Articles.

THE TREATMENT OF LEG ULCERS.*

BY THOMAS S. K. MORTON, M. D.,

Professor of Surgery in the Philadelphia Polyclinic.

It is not my object upon this occasion to describe or even mention every method that has been employed in the treatment of leg ulcers, but to present a method of dealing locally with these usually troublesome disorders that has come to be a routine practice in my hands and in those of a number of my students. As my opportunities for investigation and experiment in this direction have been unusual in extent—notably at the Polyclinic Hospital—and as the method to be described has been employed with ever-increasing satisfaction during the past few years in the treatment of a very large number of cases embracing almost every possible type and variety of ulceration, I can commend it with confidence, feeling sure that those accustomed to the usual method of treatment will under its use find their results in astonishing contrast, both as to comfort of the patient and in the rapidity and certainty of healing.

The dressing—The method, therefore, is as follows: The surroundings of the ulcer or ulcers are thoroughly cleansed with soap, brush and water, and, if necessary, shaven. The soapsuds are then washed away with simple water, and the parts douched with 1:1000 sublimate solution if the ulcer is foul, inflamed, or otherwise manifestly septic. If these conditions are absent, the bichloride may be omitted. Next, the ulcerated surfaces are subjected to the powerful but

*Read before the Philadelphia County Medical Society, May 25, 1892.

harmless antiseptic action of a spray of full strength (15 volume) peroxide of hydrogen solution. Pouring on of the agent is almost as efficient, but very wasteful. If the spray is employed, however, it is essential to use an atomizer of which every part is made of hard rubber, as the powerful oxidizing qualities of the solution will almost immediately destroy the metallic parts with which it may come in contact. The ulcer having been thus sprayed until active effervescence ceases, is then gently washed off by a stream of simple water, or by a pledget or mop of absorbent cotton saturated with the same. This carries away all detritus loosened up by the action of the peroxide. Next, the ulcerated area and one inch of the unaffected surrounding skin are covered in with strips of "Lister protective," one-half inch broad, overlapping each other about an eighth of an inch. The "protective" should be that made of very fine silk fabric coated on both sides with a mixture of copal varnish, dextrine and carbolic acid, after the original formula of Lister, and supplied by the manufacturers of antiseptic goods. Our object in using the protective is to keep the ulcer moist, to prevent friction and irritation at all times and the tearing away of reparative material at dressings, as well as to furnish a guide to the epithelial cells in their excursion across the granulations. It also acts as a capillary drain, carrying the secretions drop by drop to the edge of the strips, where a suitable dressing absorbs and sterilizes them. The strips of protective should first be soaked in strong (1:1000) bichloride solution, and then washed in simple or cold boiled water before being applied to the wound; this precaution being necessary, as the strong antiseptic probably kills or inhibits the growth of new-forming granulation and epithelial cells, and thus retards healing. Protective quickly spoils in solution, so that it must be sterilized immediately before using.

A dressing of gauze or butter-cloth, which has been wrung out of 1:1000 sublimate solution, and folded in six or eight layers large enough to overlap the protective strips several inches in all directions, is then neatly put on without creases or other irregularities. This serves to absorb and disinfect the discharges that may be transmitted into it from beneath the protective. Experiences in each individual case will determine about how many thicknesses of gauze will be required for this purpose; but the less used, consistent with attaining the object desired, the better.

Finally comes the bandage. This is to keep the dressing in place, give the vessels support, and to prevent or relieve edema. Few things are more unsatisfactory than the ordinary leg bandage that is put on with reverses up the leg, especially where the patient is compelled to stand and work upon the member during the progress of treatment. No matter how expertly it may be applied, the ordinary bandage will in a few hours, or even minutes, after its application be found in festoons about the ankle. On the other hand, a bandage that I have been using for the past five years will not only remain just as applied for days, or even weeks, and be absolutely comfortable to the wearer, but also permits the employment of the fixed antiseptic dressing for leg ulcers while the patients pursue their occupations—no matter how arduous—almost unconscious that their formerly disabling disease is still present.

This bandage is applied to the foot and ankle in the usual manner until that point immediately beneath the calf is reached, where reverses would usually be begun. Here, however, the difference becomes apparent; no reverses are made, but the two edges of the bandage are kept equally tight, and it is thus wrapped around the limb, practically allowing it to guide itself, the surgeon only being careful to keep the edges of the roller equally tense as it unwinds. Thus it will be found

that the bandage will mount upward around the calf in a spiral manner, take a circular turn around the leg just below the knee, then descend again by a downward spiral around the calf, again mount upwards as before upon the opposite side, slightly overlapping the previous turn, and so on until finally the leg will become enveloped in a bandage that might be called a figure-of-eight of the calf. It should be put on as tightly as the patient can comfortably bear, smoothly, and care should be taken that no points are left without being supported by at least one of the turns. A muslin roller, six yards long and three inches wide, will be found about the proper dimensions for this bandage. This method of giving support to the circulation of a leg is equally applicable even after the ulcer has been cured, or where swelling or varicosity exists independently of ulceration. Patients can be readily taught how to apply it, and usually give it preference to elastic stocking or rubber bandages. My experience with these latter has not been favorable; the stockings are very good when new, but soon decay, stretch, and become useless as a support, while the rubber bandage retains perspiration and often gives rise to intense irritation. Not every patient is capable of wearing either; and all, in my experience, much prefer the bandage that has been described when it is properly applied. A bandage of German manufacture can now be purchased, in which fine rubber threads run in the length of cotton webbing, which can be similarly applied and is very comfortable and satisfactory. However, it is not cheap and is prone to decay.

Redressing.—Until the parts have been rendered odorless, free of all irritation, and aseptic, it is advisable to redress the leg in the same manner every day, or at furthest every other day; also, until these conditions have been secured, to use the bichloride of mercury solution as a douche. When, however, asepsis has been attained, strong antiseptics should be discarded in redressing, as they retard healing; simple water is then used instead. Subsequently the dressing should be renewed every second day if the person is using the the extremity, but if he is in bed, dressings need not be renewed so frequently after the discharges have become scanty.

In this, as in every other method of treating leg ulcers, if the patient will consent to remain in bed or reclining, healing takes place very much more rapidly; but under the present system the number of instances where confinement is *essential* for healing is exceedingly small.

With this protective and gauze dressing, I believe that nature's method of healing is best assisted, and that under the conditions of moderate moisture and freedom from irritation—both traumatic and septic—is secured as rapid healing as can ever be anticipated. As I never expect surgery to evolve a method of uniting simple fractures more rapidly than at present, neither can I look forward to the cure of the great majority of leg ulcers more rapidly than under the favored dressing—that is, they fill up to the level of the skin and are covered over with epithelium without waste of reparative material just as rapidly as nature can possibly furnish it; the time required usually being incredibly short.

Exceptions.—For clinical and remedial purposes it is my custom to divide all leg ulcers into the following classes:

1. Simple.
2. Syphilitic, diabetic, nephritic.
3. Tubercular.
4. Malignant (principally epitheliomatous degeneration of others).

To all of these the above local treatment is applicable, except certain cases of Class 3 and all of Class 4, which require excision by the knife, with subsequent suture or grafting by Thiersch's method, or possibly amputation.

Syphilitic ulcerations require, in addition to the usual local treatment, some form of anti-specific medication. For this purpose I have employed the following mixture with great satisfaction:

℞.—Hydrargyri bichloridi . . gr. j.
Potassii iodidi . . . . ʒvj.
Syr. sarsaparillæ comp. q. s. ad. ℥ iv.—M.

S.—Teaspoonful after meals.

Modifications.—Where pus or other discharge from an ulcer is excessive, it is well to dust on the merest pinch of iodoform or aristol before applying the protective; or, what is equally effective, paint the ulcer with the pyoktanin pencil.

If granulations are slow in forming or flabby, it is wise to paint the surface at each dressing with nitrate of silver solution (15 grains to 1 ounce of water), or if greater stimulation is necessary, to scarify the ulcer and its surroundings by superficial rapid strokes of the heel of a blunt tenotomy knife or otherwise. The pain resulting from this little operation, while not severe, yet may be obviated by allowing a pledget of absorbent cotton saturated with a 5 per cent. cocaine solution to remain in contact with the surfaces for five minutes before applying the scarificator.

Exuberant granulations can most readily be removed by light parallel strokes of a fine-pointed pencil of nitrate of silver, or by scarification as above.

If the area of the ulcer be large, and the granulations are level with the surrounding skin and healthy, skin-grafting may be employed. This may be undertaken by the usual methods, or by one that I have found quite as satisfactory, based upon the practice of horsemen, who, by shaking epithelial scales from the curry-comb upon ulcers in the horse, are usually able to cure them in a very short time. So, gently scraping up a little mass of the swollen, softened, and aseptic epithelium from the skin that has been under the protective just outside the limits of the ulcer, it is gently spread over the granulations. A number of these cells will generally be found to have taken root as grafts in various parts of the ulcer at the next dressing, and will wonderfully hasten its final closure.

If healing of an ulceration is retarded by the presence of sloughs—and sloughs are very slow to separate in the absence of an active suppurative process—it may be expedient to hasten their separation. If already loose at the edges, they may usually be dissected off without pain by scissors and forceps. Otherwise, the best plan is to digest them out by means of pepsin or papoid. When pepsin is used for this purpose, I build a retaining wall of tough cerate about the ulcer, and then pour into the little reservoir thus obtained enough of the following pepsin solution to cover the ulcerated area:

℞.—Pepsin pure . . . . gr. j.
Water . . . . . ʒ j.
Hydrochloric acid . . . mj.—M.

Allowing this to act for about an hour, occasionally renewing the solution, the slough will as a rule be found almost or quite digested and liquefied, or so loosened up as to be readily removable by scissors and forceps. But much more convenient than this will be found the dusting of a minute portion of papoid or vegetable pepsin beneath the protective strips and allowing it to act until the limb is redressed next day. This succeeds well, because papoid acts best in a concentrated medium of any reaction whatever—pepsin only in a dilute acid solution.

Where the cellular tissue or lymphatics have become infected by septic material transmitted from a foul ulcer; or a phlebitis, acute or chronic, has similarly originated, I frequently apply immediately over the strips of protective

(here omitting the gauze), a sheet of lint large enough to cover in the entire affected area, and spread with an ointment composed of—

Ichthyol ammoniat.	20 parts.
Lanolin	80 "

Heavy wax-paper is put over this, and the usual bandage applied.

Ichthyol thus combined acts as a most powerful absorbent, lymphatic and circulatory stimulant and antiseptic. So also this application will be found very useful applied over the protective strips when ulcers are complicated by eczema or great induration and infiltration of surrounding tissues. When the affected area has been covered in with the ichthyol for a few days under a firm bandage, most of the infiltration will usually have disappeared, and the gauze dressing can be applied over the protective. Since learning the value and power of ichthyol I have had practically no use for plaster straps in treating even the most indurated leg ulcers.

Where ulcers are associated with excessive varicosity of veins, the question of proper treatment for the dilated vessels will arise. Any varicose condition of the leg can be kept entirely under control, and the patient comfortable and able to follow his avocation, by means of the bandage that has been previously described, provided, however, that the dilatation does not extend above the knee. But if the veins of the thigh are also involved, there is no method of giving them adequate support, so that if they are very troublesome, excision *en masse* is the only advisable resource. Of course, varices or isolated veins below the knee can be likewise dealt with if such radical treatment for any cause (such as constant recurrence of ulceration) be considered advisable. I have recently had several cases in which I had recourse to very extensive excision of varices of the thigh and isolated veins of the leg with the most satisfactory results. These I expect to present in detail in a future communication.

TREPHINING FOR ABSCESS OF THE BRAIN; EVACUATION OF PUS; RECOVERY.*

BY WM. H. MORRISON, M. D., HOLMESBURG, PA.

On February 25, 1892, I was called to see Mrs. S. L., white, aged thirty-nine years, the statement being that her scalp had been cut. She with two others had been drinking, and in a row that followed she had received the injury. I found a cut through the left side of the scalp, one and one-half inches in length, parallel with the Rolandic line, and one inch in front of it. The upper extremity of the wound was one inch from the median line. Immediately beneath this wound, and corresponding to it in length and position, was an injury to the bone, as though it had been cut with an edged instrument. This cut was one-fourth of an inch posterior to the coronal suture. There was no fracture of the external plate, and a probe passed into the cut in the bone did not seem to penetrate beyond the diploë. There were no symptoms of brain-injury. The patient had not lost consciousness, although the blow had forced her against the wall.

I felt that it was very probable that the internal plate had been fractured and considered the advisability of immediate trephining; but, as the woman presented no symptoms, and it being late at night, and as I was separated from assistance by three miles of muddy roads, I decided to postpone operative interference and wait the development of symptoms. The wound was thoroughly cleansed with bichloride solution, approximated by one suture, and an iodoform and corrosive sublimate dressing applied. The attendants were directed to watch

*Read before the Philadelphia County Medical Society, May 25, 1892.

the patient carefully, and to notify me at once if there were observed any twitching or weakness of the muscles of the right side. That night there was some nausea and vomiting, which continued during the following day, and then ceased. During the next three or four days the patient did well, there was no fever and no change in the pulse, and I began to think that had I trephined I should have made a mistake. On the third or fourth day the patient commenced to complain of severe pain in the left temple. She, however, slept well at night and rested comfortably during the day, and, as I knew, from previous experience, that she was not in the habit of minimizing painful situations, I did not attach as much importance to this symptom as I might otherwise have done. She was kept quiet in bed, and bromide of potassium administered. The bowels acted regularly under small doses of laxatives, and the vomiting and nausea did not recur.

March 3rd (seventh day). There was no change in her condition. She still complained of the pain in the temple. The pulse was normal, the temperature as taken in the mouth was not above normal. The wound was carefully examined but there was no suppuration. The scalp seemed a little puffy at the position of the injury and the edges of the wound. The latter had united and I separated the edges with a probe, but no pus was present. The wound was then redressed. The following day, March 4th, I did not see her.

March 5th (ninth day) I saw patient at 9 A. M., and was told that the previous afternoon she had begun to lose power in the right arm and leg, so that she had to be assisted in and out of bed. When I saw her, she was in a semi-stupid condition, with no delirium and no convulsive movement. There was complete paralysis of the right arm and leg, the right side of the face and tongue, and thick, indistinct speech. I ordered the head shaved and scrubbed, and at once made preparations for opening the skull.

The operation was done at noon. The patient was slightly etherized, and a flap three inches wide, with its base downward, and its apex corresponding to the upper extremity of the scalp wound, was turned back. For three-fourths of an inch on each side of the wound in the skull, the periosteum was found separated from the bone, but no pus was present. A half-inch trephine was applied immediately in front of the middle of the bone injury, and a disc of bone one-fourth of an inch in thickness removed. It was then found that the internal plate had been separated from the external plate for half an inch on each side of the cut. With rongeur forceps the whole of the seat of fracture was removed, leaving an opening one and a half inch in length, by one inch in width. The dura protruded into the wound and slight pulsation was observable. The membrane was covered with inflammatory exudate, in which were imbedded fragments of the internal plate. At the upper part of the opening was a small, dark, extra-dural blood-clot, about three-fourths of an inch in diameter. There was no sign of suppuration external to the dura. The fragments of the bone were then picked away with forceps. One of the fragments seemed to have penetrated the dura, and in drawing it away an opening was made in the membrane, through which escaped about one fluid-ounce of yellowish-green pus. The opening in the dura was then enlarged, care being taken not to separate the adhesions which had formed between the dura and pia mater, and thus open up new areas for infection. The cavity of the abscess was found to be one and a half inches in depth. It was carefully washed out with plain boiled water, and a rubber drainage-tube was inserted. The liquid left in the abscess cavity could be seen distinctly rising and falling in the drainage-tube with each pulsation of the brain.

The flap was then replaced and secured with silk sutures, the drainage-tube being brought through the original wound. The scalp was thoroughly irrigated with corrosive sublimate solution and an iodoform and bichloride dressing applied.

5 P. M. of the same day she was resting quietly. The pain had disappeared. There was no nausea. She could speak a little more distinctly, and replied intelligently when spoken to, although still somewhat dull.

9 P. M. Condition the same. Temperature normal, pulse 80 per minute.

During the week following the operation the condition continued satisfactory. The temperature, which was taken twice daily, at no time went above 98.6°. The pulse ranged from 70 to 80 per minute. There was no pain. The wound was dressed at intervals of two or three days, and at each dressing was washed out with a solution of peroxide of hydrogen. There was little discharge from the abscess, and the drainage-tube was gradually shortened. During this period, while apparently rational on most points, she presented some delusions, the principal one being that she was detained on a boat away from home.

By March 12th the paralysis had nearly disappeared from the muscles of the larynx and face. The tongue was protruded nearly straight. At this time there was some slight movement of the thigh muscles when the leg was pinched. There was no anæsthesia at any time. The stitches in the flap were now removed and primary union found throughout the wound, with the exception of the point at which the drainage-tube emerged.

The patient continued steadily to improve, and on March 23rd the following note was made: "The abscess cavity is almost entirely closed, and the drainage-tube was removed. There has been no discharge for some time, and a short tube has been retained simply to keep the external wound open as a matter of precaution. The paralysis of the tongue has disappeared. The voice is almost normal. The appearance of the face is natural. The thigh and leg muscles have been steadily gaining in power. She can move the foot and draw up the leg when bidden. No movement of the muscles of the upper extremity can be detected."

24th. The use of faradism to the arm and leg was begun, and the current induced decided contraction of the muscles.

26th. She is able to flex and to extend the fingers.

31st. She is able to be out of bed and walk across the room without support. The arm movements are increasing in force. The drainage-tube opening has closed, but there is a distinct depression of the scalp at the seat of the abscess. The mental condition is normal, but she is easily excited.

From this time she steadily improved and gained in strength, and has now practically returned to her normal condition.

A study of this case offers several interesting and instructive lessons. In the first place, it forcibly illustrates the danger of delay. The trephine should have been applied at once, for although there was no fracture of the external plate, but simply an incision extending through it to the diploë, yet the character of the wound rendered it almost certain that the internal plate had been fractured. I recognize the advisability of immediate trephining, and have to offer in palliation for the sin of omission only the facts before stated.

The absence of symptoms, although not unusual, is of interest. Dr. Chas. B. Nancrede,† in a paper on "Surgical Interference in Cerebral Abscess," in speaking of this condition, says: "Mental hebetude, slow pulse, headache, perhaps rigor, subnormal temperature, constipation, and at the end sudden development of the compression symptoms, as evidenced by profound coma, hemiplegia,

† Transactions American Surgical Association, 1884, vol. iii, p. 94.

respiratory failure and death, seemed to have in all cases marked the occurrence of brain abscess." In this case, prior to the appearance of the signs of compression of motor areas, there was an absence of all the symptoms noted above with the exception of the pain and the non-elevation of temperature. I regret that the exact temperature was not recorded; it is simply noted that the temperature was not above normal. Dr. Nancrede, in the article referred to, lays stress upon sub normal or normal temperature as a diagnostic feature of abscess involving the cerebral tissue, saying that "where high temperature is noted, either the pus collection is a localized suppurative arachnitis or there is meningitis in addition to the abscess."

The position to which the pain was referred corresponded very closely with the situation of the abscess, although Dr. Spitzka† states that "the pain is sometimes localized, but the subjective localization does not correspond to the actual site of the morbid focus."

The abscess in this case was situated just anterior to the middle of the ascending frontal convolution, and, as would naturally be supposed, the chief brunt of the pressure fell upon the centers for the upper extremity, while those for the leg and those for the face were not so seriously implicated. The muscles of the face, tongue and larynx began to regain their power within a short time after the pressure was relieved. Motion in the muscles of the leg was first observed at the beginning of the second week, but three weeks elapsed before voluntary movement reappeared in the arm.

So far as I am aware this is the second case of recovery after trephining for cerebral abscess ever recorded in this city. Dr. D. Hays Agnew,‡ in his paper on "The Present Status of Brain Surgery," read before the American Surgical Association at its last meeting, collected from the practice of surgeons of this city eighteen cases of trephining for abscess of the brain following traumatism, aural disease, and syphilitic necrosis, and says, "All the patients died, life in no instance being prolonged beyond fourteen days." Looking over the literature relating to cerebral abscess in this city, I found that on November 7, 1888, Dr. Thomas G. Morton§ had reported to the College of Physicians a case of trephining for abscess of the brain, and at that time the case presented every prospect of recovery. On inquiry from Dr. Morton I learn that the case eventually made a perfect recovery, but that in sending to Dr. Agnew a list of his cases this one was accidentally omitted. The history of Dr. Morton's case is briefly as follows:

The patient was a colored boy, ten years of age, who had received a lacerated wound of the scalp, which was cleansed and closed, and the boy sent to the Pennsylvania Hospital, September 29th, 1888. The wound suppurated freely. The boy became delirious, and there were symptoms of compression. Dr. Morton's attention was then called to the case. The skull was exposed and a stellate fracture of the temporo-frontal region discovered. The trephine was applied and a number of pieces of separated bone removed. An incision carried into the bulging brain mass evacuated about an ounce of pus and broken-down blood-clot. The dural incision was then increased and disorganized brain substance and disorganized clot removed with the dull curette. The wound was closed, drained, and an antiseptic dressing applied. Convalescence was rapid, and the patient was discharged thoroughly recovered on January 4, 1889.

In conclusion, I desire to express my indebtedness to my friends, Dr. H. A. P. Neel and Dr. E. E. Keiser, for valuable aid and counsel, and to my brother, Fred. S. Morrison, for much assistance in connection with these cases.

†Pepper's System of Medicine, vol. v, p. 795.
‡Transactions American Surgical Association, 1891, vol. ix, p. 24.
§Transactions College of Physicians of Philadelphia, 1888, vol. x, p. 447.

Society Reports.

THE AMERICAN HEALTH RESORT ASSOCIATION.

This Association met at the Tremont House, Chicago, June 30, and held three sessions.

There were present delegates representing Canada, Michigan, Massachusetts, Wisconsin, Florida, New Hampshire, New York, Pennsylvania, California, Illinois, Vermont, Colorado, Texas, Iowa, New Mexico and Central America.

A large correspondence was read by W. A. Chatterton, Secretary, from the absent members in various parts of the country.

The President, T. C. Duncan, M. D., of Chicago, then delivered a lengthy address, in which he outlined the good work of the Association, and how it was appreciated by the profession, enabling them to select climates adapted for the various cases of consumption. From reports received from the winter points, New Mexico had proven the most satisfactory. This is of interest to the profession who are trying to save some of the "hundred thousand consumptives" who die annually in this country.

Dr. J. F. Danter, of Toronto, Canada, read a paper on the "Climates and Resorts of British America."

A report on the climate of Manitoba was read, from Dr. Clark, of Winnipeg.

The climate of New Brunswick was presented by Dr. J. Z. Currie.

From these reports it seems that there are a large number of consumptives in Canada, especially in the eastern provinces.

Dr. Adam Miller read a paper on sun spots and magnetic influence in disease.

The climate of Nebraska was presented by Dr. Brown.

The climate of California and its resorts were presented in papers by Drs. J. D. Hartley and S. W. Andrews, of Chicago.

Dr. W. P. Roberts, of Boston, read a report on the climate of New England, in which he reported that 15,000 die annually there from consumption.

"Consumption in Michigan" was the subject of a paper by Dr. Veenboer.

Dr. O. W. Gordon, of Council Bluffs, reported his disappointment in visiting various resorts, and spoke highly of New Mexico.

A report from Dr. A. Petin, of Las Cruces, N. M., formerly of Paris, was read, in which he said they had almost constant sunshine, less than two inches of precipitation in twenty-eight months, and that consumptives sent there were all doing well.

A report on the Adirondack region was read from Dr. Skinner.

Dr. B. James, of Philadelphia, contributed a paper on "Climate Maxims."

The climate of Costa Rica was presented by Dr. Buchanan.

Dr. A. S. Butler reported on the climate of Honduras.

"Texas as a Resort for Consumptives" was the title of a paper by Dr. Marshall.

Reports on mineral waters were presented from Las Vegas Hot Springs, N. M., Eureka Springs, Ojo Caliente Hot Springs, N. M., Costa Rica and Londonderry.

Prof. I. N. Danforth gave an address on "Mineral Waters, their Analyses and Uses."

He said the profession was being imposed upon by imperfect and fraudulent analyses. In the first stages of Bright's disease he thought that bland water should be used, and in the second, Lithia waters.

Prof. W. S. Haines made a valuable report on bacteria in mineral and potable waters. In some mineral waters he found 2 bacteria to the cubic centimeter, and in some drinking water he found as high as 8,000.

A large number of members were admitted to the Association.

It was reported that a Congress of Climatologists would meet in Chicago next year, and it was voted that the Association meet with it.

The following officers were elected: T. C. Duncan, M. D., President, Chicago; J. F. Danter, M. D., first Vice-President, Toronto, Canada; I. N. Danforth, M. D., second Vice-President, Chicago; W. P. Roberts, M. D., third Vice-President, Boston, Mass.; T. S. Hoyne, M. D., Treasurer, Chicago; W. A. Chatterton, Recording Secretary, Chicago; J. D. Hartley, M. D., Corresponding Secretary, Chicago; W. W. Van Baun, M. D., Philadelphia; Professor W. S. Haines, M. D., Chicago.

The full proceedings and papers will be published shortly and all members will be supplied with these valuable and interesting transactions. For further particulars address J. D. Hartley, M. D., Corresponding Secretary, 1204 Milwaukee Avenue, Chicago, Illinois.

HOW TO RESTORE HEALTH.

Whoever would perform efficiently the difficult task of nursing the sick must first curb his belief in marvelous cures, in extraordinary means, and hearken only unto the voice of reason; for what is necessary for preservation of health is indispensable for the sick; and only he who exactly follows the best directions for general care of health—always, of course, with modifications in various cases of sickness—can make pretensions of a noble fulfilment of duty. Seven things are absolutely necessary to maintain or restore health; fresh air, light, warmth, rest, cleanliness, the correct selection and well-timed offering for food and drink. The lack of one of these requisites may hinder the exercise of a physician's skill and bring to naught both good-will and wisdom.—Hermine Welton, *The Chautauquan*, February, 1892.

FOR THE SICK BABIES.

The *Chicago Daily News* Lincoln Park Sanitarium will soon open for the reception of its guests—the thousands of sick babies for whom it cares each summer as a hen cares for her chicks. The great building is still in the hands of the W. H. Stubbing Company, painters, and when it is opened for its kindly mission will be one of the handsomest attractions in Lincoln Park. In many ways the building has been improved, and the matron and medical staff will be prepared to care for at least 50,000 babies during the heated term. Last summer more than 36,000 babies and mothers enjoyed the hospitality and saving hand of this unique and peerless charity.

The "Country Week" department of the *Daily News* Fresh-Air Fund will soon be prepared to send guests to country homes. Many "charity globes" have been placed in friendly drug stores and other business places, and the generous public has started in early to help the poor little ones who cannot help themselves.

What is the best medium for trichina? I have tried glycerine, Farrant's solution, and dry. They all disappear within a year.—H. M. Farr.

Trichinous muscle should be well hardened in alcohol, then cut, stained with carmine, and mounted in Farrant's solution, or balsam; will be as permanent as any other pathological mount.—*Microscope.*

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BALTIMORE, JULY 30, 1892.

Editorial.

THE SCOPE OF THE NEW MEDICAL LAW.

It is the editor's duty to receive with meekness such castigation from his readers as may be called forth by the crude and ill-digested opinions which flow from his pen whenever he ventures to express his own ideas in regard to public matters. In this week's mail we have received two such disciplinary notes: one of these we returned to the writer in New York: the other, from an esteemed fellow-physician, we now present to our readers.

Editor Maryland Medical Journal:

The editorial in your issue of July 16th in reference to "The Medical Law as it Concerns Doctors Now Practising" contains a couple of paragraphs so misleading that I wish to promptly correct the impressions you create, as, appearing in the JOURNAL, they might be regarded as authoritative upon a subject of such vital importance to the profession as this Medical Law. Utterances as to its operation and results should be the outcome of careful consideration of the subject. The main purpose of the Law is to elevate the standard of medical education, and, by the protection which it throws about the entrance to professional work, to give to the physicians of the State in their collective capacity the character, dignity and influence which belongs to a learned profession. As a member of the Examining Board I conceive this to be its purpose, and in the discharge of my duties as such shall act under the influence of this interpretation. You say "The new board of examiners may not molest any person hereafter beginning to practise medicine in Maryland, unless they have before them reasonable proof that such persons have never, previous to the passage of the Law, practised medicine in any other of the United States." "It will appear, therefore, that considerable caution must be exercised in the arrest of practitioners who hail from other States."

Permit me to say that nowhere in the Law are any words indicating that it belongs to the Examining Board "to molest any person hereafter beginning to practice," etc. Violation of its provisions is termed a misdemeanor, and will be acted upon as such by the "officers of the law." The Board of Examiners have nothing more to do with the enforcement of the Law than a county medical society or individual physicians, and I submit that it was incumbent upon the MARYLAND MEDICAL JOURNAL to know that fact when it editorially commented upon the Law. As I said before, it is a subject of the greatest importance to the profession and it is imperative that every care be taken to have its provisions and purposes thoroughly and correctly understood, that physicians throughout the State may co-operate intelligently that the profession may receive all that it is intended to secure for them and the public.

In the remainder of the quotation is a strong intimation that any one practising medicine or surgery elsewhere, prior to the passage of the Law, will not be amenable to its provisions. If such an interpretation is correct, the good expected will not be realized for reasons so obvious that it is not necessary to name them. Upon the construction of this prohibitory paragraph (No. 39) of the Law, I admit that there may be an honest difference of opinion, but it is exceedingly unfortunate the MARYLAND MEDICAL JOURNAL should so construe it.

The members of the Examining Board appointed by the Medical and Chirurgical Faculty regard that paragraph as prohibiting anyone not now practising medicine and surgery from beginning to practise medicine and surgery after the passage of the act unless they conform to the Law.

It is not for us to consider what a man was doing before he came into Maryland. He may have been a corn or catarrh doctor, a politician or a Statesman, or what not, it matters not to us, but when he comes into Maryland and attempts to practise medicine or surgery he must comply with the requirements of the General Assembly or take the consequences.

Such I regard as the necessary and simple construction of the Law, and on it I propose to act until a higher authority than a local magistrate places on it a judicial decision; and until such a judicial decision is made, adverse though it may be, I submit that the interests of the profession will be best promoted by acceptance of the Law without equivocation or doubtful construction of its most important features.

Yours respectfully,

Hagerstown, July 17, 1892. J. McP. SCOTT.

A REPLY.

In response to this correction we would state that we apologize to the Board for suggesting that it had any duties of an aggressive sort. We now, on a second reading of the Law, perceive that the Board is not empowered to act in any sense as a vigilance committee for the "spotting of suspicious characters." Its duty is simply that of propounding questions, passing upon examination papers, and issuing licenses.

We might wish that it had also the right to summon new-comers in the field of medicine before it, as this would remove to an official body the task of instigating proceedings against persons supposed to be practising illegally—a task which must now devolve on individual practitioners, unless the medical societies or the public come forward in the matter. At present we believe that in Baltimore those citizens or associations of citizens who have undertaken to secure the enforcement of the liquor laws and kindred laws are very much discouraged at the little success which has attended their efforts. If we are wrong in predicting a like issue in prosecutions here under the medical law, we would be glad to be taught the reason for the difference.

In regard to the disputed question "to what persons does the Medical Law apply," we would respectfully refer our readers to the text of the law itself, of which a neatly covered copy may be obtained at the JOURNAL office at the reasonable price of ten cents.

We will be glad at any time to hear the views of correspondents on this subject.

Medical Progress.

TREATMENT OF INEBRIETY.

Dr. Charles L. Dana has made a very careful study of 614 male alcoholics treated at Bellevue Hospital. He believes that strychnine has a certain degree of specific effect in inebriety, and in alcoholic intoxication. In acute alcoholism, when the system is overwhelmed with the poison, one-sixtieth of a grain every two or three hours; in the chronic form, it should be administered in good doses for a considerable time. In ordinary acute delirium of alcoholism, twenty to forty grains of chloral, repeated in smaller doses in two or three hours, and combined with digitalis and strychnine, is the safest and surest means of controlling the excitement and securing sleep. A preliminary laxative, and a careful diet of hot milk and beef tea with red pepper, should be insisted upon. In febrile delirium tremens, depressants must be used with care; cold baths or cold wet-packs, with friction, must be applied every two or three hours while the temperature remains high. Hypodermic injections of morphine are rarely needed, and he does not advise them.—*N. Y. Medical Record.*

THE TREATMENT OF METRORRHAGIA.

Edis (*British Medical Journal*, No. 1630, p. 648) considers the various conditions that give rise to metrorrhagia, and indicates the best means of treatment. When uterine hæmorrhage results from constitutional or general conditions, its repression is not always wise. In certain cases of heart-disease moderate uterine hæmorrhage seems to relieve the cardiac symptoms. In such cases potassium bromide, with strophanthus, digitalis, or aconite, is indicated. Iron is also useful. If the function of the liver be deranged, attention to diet, abstention from alcohol, encouraging the action of the skin and the administration of a few grains of calomel, followed in the early morning by a brisk saline aperient, will be attended with good results. If disease of the kidneys exists, vicarious action of the skin and bowels, by means of diaphoretics and purgatives, should be encouraged. The reliable remedies available for controlling uterine hæmorrhage are few in number.

Ergot is one of the most potent: its efficacy is increased by combination with strychnine and cinchona. Hydrastis canadensis is a valuable agent in many cases of uterine fibroid. Hamamelis is useful in some cases. Ordinary astringents, such as gallic and sulphuric acids, have little influence in restraining hæmorrhage. Quinine and strychnine, alone or in combination, will often succeed in controlling hæmorrhage when the system is depressed, as a result of repeated or protracted loss of blood. Potassium bromide is one of the best remedies in cases of hæmorrhagic chlorosis, ovarian irritation, or hematocele. Potassium chlorate and borax, in combination with ergot and cannabis indica, have been recommended. When the hæmorrhage has been severe or protracted, opium has a wonderful restorative effect. Combination with quinine or cinchona seems to enhance the value of the remedy. Iron should not be resorted to when the presence of a foreign body in the cavity of the uterus is suspected. On the other hand, when from antecedent anæmia, the blood has become so attenuated as to pass readily through the capillaries, and in some cases of intra-mural fibroids, iron does much good. Locally the hot vaginal douche, at a temperature of from 110° to 115° F., is often of service. In all severe cases absolute rest in the horizontal position, preferably in bed, is indicated. The application of carbolic acid by means of a suitable probe to the cervical canal and even to the cavity of the uterus may, in appropriate cases, control the hæmorrhage for a time. Free scarification of the cervix, by relieving congestion, sometimes succeeds in arresting uterine hæmorrhage. When, without recognizable cause, uterine hæmorrhage persists and ordinary remedies have failed, the cervix should be dilated and the cavity of the uterus explored.

HAY FEVER.

L'Union Medicale recommends the following snuff for hay fever:

℞.—Acid. boric. pulv. . .	gr. xxxiij.
Acid. salicylic . .	gr. xxxviiss.
Cocaine mur. pulv. . .	gr. iss.

M. Sig.—For snuff.

For the eye symptoms a solution of sulphate of copper or sulphate of zinc, for a wash, 10 drops of iodide of ethyl or three drops of nitrate of amyl may be inhaled at the onset of an attack, and the patient sent to a different climate or place.—*Ex.*

THE CLINICAL COLLEGE OF MEDICINE AND SPECIALTY HOSPITAL.

The Clinical College of Medicine and Special Hospital, of Chicago, has been organized to "supply to students the instruction and facilities for clinical work, now obtained only by hospital internes and attendance at post-graduate schools." A suitable lot has been secured, and work upon the buildings is to be begun immediately. The course of study will cover thirty-six months of actual attendance at the College, Dispensary and Hospital, divided into twelve terms of three months each. The classes attending each term will be limited to six students, and their entire time in the college and hospital will be occupied by practical work and personal instruction in the laboratories, in the clinical rooms of the dispensary, and in the hospital. No didactic lectures will be given. Advanced students will be required to assist in operations and nurse patients in the hospital, so as to thoroughly familiarize themselves with the after-treatment in surgical cases and the various phases of disease to be seen in the medical wards.

The requirements for admission to this college will be of the highest grade. The student must either have received a literary or scientific degree, or pass a

thorough examination. Candidates for graduation will be required to present a thesis on original work in some department of medicine or surgery. During the last two terms of the college course every facility will be offered to students in the different laboratories for original research.

The Directors are now receiving applications from candidates for professorships and demonstratorships. Further information can be obtained by addressing the Secretary of the Board of Directors, S. A. McWilliams, M. D., 3456 Michigan Avenue, Chicago, Ill., or the President, J. E. Harper, M. D., 1101 Masonic Temple, Chicago, Ill.

SKATALOGICAL MEDICINE.

In China pills made from the dung of the Grand Lama of Thibet are used as infallible antidotes to disease. Dr. Mew, of the United States army, recently had the opportunity of analyzing some of them, and he stated that he found "nothing at all remarkable" in them. These sacred pills had been preserved in a silver reliquary, elaborately chased and ornamented, and they came into the possession of Mr. W. W. Rockhill, Secretary of the Legation of the United States in Pekin, through whom they were transmitted to Dr. Mew. Strange as this may seem to those who have not studied the subject, it is not at all remarkable to the ethnologist. Human and animal dung has always been a favorite medicine in some quarters of the world. Such things are never considered disgusting, the Grand Lama offers his excrement to a suffering world as a precious remedy, and the material is provided with great and solemn ceremonies and many prayers. It is not considered by any means a mere excrement, but as a symbolical alvine dejection of miraculous virtue. From the day of Pliny the dung of almost every kind of animal has been used in medicine. Dog dung mixed with honey was prescribed for sore throat, and wolf dung as an anti-colic. Goat dung was considered of great value in tumor of the spleen, and cat dung for gout in the feet. Lion dung was an anti-epileptic, and mouse dung in the constipation of children. Dr. Jacob Hunerwolf, in 1694, actually wrote a treatise on mouse dung as a laxative, in which he very highly extrolled the remedy. Human urine is considered in many places as a most valuable tonic medicine. Daniel Beckherius, in his "Medicus Microcosmus," published in London in 1660, recommends a drink of one's own urine, taken while fasting, for obstruction of the liver and spleen, for dropsy and jaundice. The urine of boys was recommended in fever, and a "spirit of urine" was distilled for gout. Boyle, the great philosopher, esteemed human urine so highly as a medicine that he declared that a full account of its virtues would fill a volume. Dr. Neale, in the *Practitioner*, November, 1881, p. 343 *et seq.*, wrote a paper on urine, and compared it with beef-tea and Leibig extract. "Many writers have endeavored to impress the public and the profession with the true value of beef-tea, namely, that it is not a nutrient, but a stimulant, and that it mainly contains excrementative materials." Dr. Brown-Séquard's remedy for the invigoration of the aged and debilitated would not be considered at all remarkable by those savage Australians, of whom Mr. P. Beveridge tells in his "Aborigines of Victoria and Riverina." Pliny mentions the use of human semen as a medicine, and Avicenna prescribed it for gout. Paullini advises the dirt from soiled stockings as a remedy for epistaxis (p. 52). Dried and powdered after-birth was used as an anti-epileptic, and secundines were used for the same purpose. The curious investigator of the odd proposals and practice of men of medicine and medicine-men will find in Captain Bourke's "Scatological Rites of All Nations" a vast amount of information on this and kindred subjects. He has compiled his great work from one thou-

sand authorities, and though not intended for general perusal, it is one that will interest and inform those at least who consider that the "proper study of mankind is man."—*British Medical Journal.*

YOUR VACATION.

Just now as summer time with its heat is upon us, we feel constrained to recho our annual reminder to the hard-working physician to take a vacation.

Go away to the hills and woods, or the seashore, or to any place where you can have a change of scene, and rest from business and its carking cares.

Go, if you lose business and money. The rest of your mental faculties and your body will enable you to do more and better work when you return.

We all know how short and full of care and pain life is, and we, therefore, should not forget the duty we owe to ourselves of occasionally shaking the dust of business and routine rounds of every-day work off our feet, going away from all for awhile to unbend and recuperate.

Let us not allow the press of business to defeat this determination to have a vacation—but let us all, or as many as can, go away.—*Med. Prog.*

WARTS AND PORPOISES.

Dr. Louis Lewis writes to the *Times and Register:* "Last month a gentleman called on me to be examined for life insurance. I noticed that the backs of his hands and fingers presented a large array of unsightly warts ('verruca vulgaris'), which he said had hitherto resisted all treatment, either returning or refusing to go. He went to the West Indies, and, during the voyage, shot a porpoise, which was hauled on deck, and, in cutting up the carcass, his hands were freely besmeared with the blood. To his surprise, every wart vanished in short order, and none have come back. Returning to Philadelphia to-day, he has a perfectly clean pair of hands. I have often heard that pig's blood will remove warts, and have received the news with a large grain of salt; but here is a singular coincidence, to say the least of it, if only in the resemblance between a porpoise and pig. I should like to give this 'remedy' a trial; but few druggists keep porpoises in stock, and I do not think I could shoot one."—*N. Y. Medical Record.*

SPRAY FOR WHOOPING-COUGH.

The *Journal de Médecine de Paris* for March 27, 1892, recommends the following prescription for whooping-cough:

℞.—Carbolic acid (crystallized), . . . gr. iii.
Borax,
Bicarbonate of sodium, of each . . 5i.
Glycerin,
Water, of each . . . . . 5i.—M.

Sig.—This is to be used in a spray from an atomizer.—*Therapeutic Gazette.*

HEREDITARY TRANSMISSION OF MULTILATIONS.

Dr. C. G. Lockwood, of New York, has recently published some interesting results of his experiments on the hereditary transmission of mutilations. White mice were selected on account of their rapid breeding, as they begin to breed when they are thirty days old and breed every thirty days. He bred them in-and-in for ninety-six generations, destroying all the sickly and defective ones, and in this way obtained a larger and finer animal than the original pair. His experiments in breeding their tails off were done by selecting a pair and putting them in a cage by themselves and clipping the tails of all of the young. When these were old enough to breed he selected a pair, and when they had young,

clipped their tails. By continuing this breeding, in the seventh generation he got some young without tails and finally got a perfect breed of tail-less mice. By taking one with a tail and one without a tail, and alternating the sexes in each generation, he finally again got a breed of all-tailed mice.—*Boston Med. and Surg. Jour.*

RATS BREED DISEASE.

Dr. S. E. Weber, assistant State veterinarian of Pennsylvania, read before the Keystone Veterinary Medical Association, at the College of Physicians, a paper entitled "The Rat a Disease Breeder." The essayist advanced the theory that the rat is a transmitter of some of the most dangerous diseases which afflict humanity, chief of which is tuberculosis or consumption. He cited the results of post-mortem examinations on more than 1,000 of the animals in proof of the theory, and then discussed the best way of getting rid of them.

Dr. Weber said that nowhere does the ubiquitious rat do more harm as a disease transmitter than in the farmyard and barn, where he comes in contact with the cattle and horses. The paper, in part, is as follows:

"From time whereof the memory of man runneth not to the contrary the rat has been looked upon as one of the most persistent enemies of the human race. He has destroyed the garnered treasures of millions of farmers, rendered millions of acres valueless to the husbandman, undermined houses without number, and even depopulated whole provinces by bringing the labor of man to naught. His record does not rest upon the traditions that tell us of the wonderful doings of the Pied Piper of Hamelin, the important part he played in making Dick Whittington "twice mayor of London," and the just punishment he meted out to Bishop Hatto in his corn-choked castle on the Rhine. He has been a pest in every clime, and will so continue to be until, in the development of the distant future, he shall either disappear or evolve into some harmless, guiltless creature as useless as the axolotl of Mexico, or the lazy hellbender that rests his boneless body in the muddy bed of the Miami river.

There is but one good word to say for the rat. While at all times prompt to take for his own use the choicest food that man can provide for himself, the rat does excellent service as a scavenger and consumes tons of refuse material which, if allowed to putrify, would become the certain means of pestilence and death. It is only as a scavenger that he seems to have been designed: and it is of record that the terrible plagues which used to turn the towns and cities of Western Europe into charnel-houses have been but little known in these places since rats began to be among the greatest factors in the economy of the animal world.

"The plagues and pestilences of bygone centuries do not decimate the populations of Western Europe nowadays, it is true. But, while they have given their own stamping ground a wide berth, they have not been rooted out by any means. It is possible that the rats who helped to rid England of a pestilence carried the germs of the disease to Turkey or to Hindostan. This brings me to the consideration of a subject which will at once present itself to the mind of the medical scientist as one of the most important ever called up for discussion.

"When the reader thinks of the countless number of rats that infest the regions occupied by human beings, of their wonderful reproductive power, and their seemingly causeless but rapid migration from one dwelling place to another, hundreds of miles away, he must admit that if it is possible for the rat to convey disease germs from point to point, this power for evil is incalculable. When he left plague-stricken London and sought another field, did he leave the plague behind, or did he keep a share of it do distribute elsewhere?

"I have reason to believe that the rat is a transmitter of some of the most dangerous diseases which afflict humanity—diseases that have for ages baffled the skill of the ablest scientists in the world."—Baltimore *Sun*.

"GOLDEN GEMS OF GOODELL."

These, recently enunciated, should be printed in large type and placed prominently before the eyes of every doctor in the sacred sanctum wherein he mostly pursues his studies. They are as follows, viz:

First, always bear in mind "women have some organs outside of the pelvis."

Second, each neurotic case will usually have a tale of fret or grief, of cark and care, of wear and tear.

Third, scant or delayed or suppressed menstruation is far more frequently the result of nerve exhaustion than of uterine disease.

Fourth, anteflexion is not *per se* a pathological condition. It is so when associated with sterility or painful menstruation and only then does it need treatment.

Fifth, an irritable bladder is more often a nerve symptom than a uterine one.

Sixth, in a large number of cases of supposed or of actual uterine disease which displays marked gastric disturbance, if the tongue be clean the essential disease will be found to be neurotic, and must be treated as such.

Seventh, almost every supposed uterine case, characterized by excess of sensibility and by scantiness of will power, is essentially a neurosis.

Eighth, in the vast majority of cases in which a woman takes to bed and stays there indefinitely, from some supposed uterine lesion, she is bedridden from her brain, and not from her womb.

Lastly, uterine symptoms are not always present in case of uterine disease, nor when present, even urgent, do they necessarily come from uterine disease, for they may be merely nerve counterfeits of uterine disease.—*Atlanta Med. and Surg. Jour.*

PUERPERAL INSANITY.

In closing an article upon this important theme (*Journal American Medical Association*, July 16, 1882), Dr. Rohe, of Baltimore, remarks:

Time is lacking to review here the unsatisfactory theories that have been propounded to account for the origin of puerperal insanity. I offer here no theory, but submit the cases which I believe justify the following conclusions:

1. Puerperal insanity is, in at least the large majority of cases, an infection psychosis.

2. Without rejecting the influence of other factors, such as heredity, anæmia, exhaustion, mental shock and distress, careful observation will show that few cases of puerperal insanity occur without preceding or coincident puerperal infection.

The reasons for this opinion may be briefly summed up as follows:

1. Puerperal insanity occurs in the great majority of cases within the first ten days after delivery—about one-half in the first five days—the same period during which puerperal infection usually occurs.

2. It is usually accompanied by elevation of temperature and other evidences of febrile disturbance.

3. The clinical form in which puerperal insanity manifests itself is, in the majority of cases, that of acute, delirious, or confusional mania. Depressive states are rare except as secondary forms. In other words, the most frequent condition is one most closely resembling febrile delirium.

4. The death-rate is much higher than in simple mania. Death occurs from exhaustion, usually with high temperature and rapid pulse.

5. Post-mortem examinations, though apparently infrequent in these cases, have shown grave involvement of the pelvic viscera.

6. Examinations of the pelvic organs during life show lacerations of the perineum and cervix uteri (facile channels of infection in the puerperal woman). As secondary conditions are found intra-pelvic (peritoneal) inflammations, and consequent abnormal locations, fixations and congestions of the uterus, tubes and ovaries.

7. The results of operations seem to show that removal of local sources of irritation increases the chances of recovery from the mental disease.

DR. MUNDE ON CHRONIC SALPINGITIS.

From an interesting article by this well-known authority in the *American Journal Obstetrics*, July, 1892, we clip a few suggestive sentences:

Now, I can fairly say that of the many hundred cases of this affection which I have seen in the chronic stage, but a very small proportion, as I have already stated, has seemed to me to warrant the removal of the diseased appendages. On the other hand, in looking over my records at the Mount Sinai Hospital for the last eighteen months I find forty-seven cases of chronic salpingo-oöphoritis recorded, all of which were treated by the iodine and glycerin, hot douche, and warm sitz-bath methods, and of whom thirty-eight were discharged improved, four cured, and five unimproved; the average duration of the treatment being three weeks. Of the unimproved I should say one remained in the hospital only two days, another three days, a third six days, a fourth seven days, and a fifth fourteen days—evidently too short a time in any case to expect any benefit from treatment. I have in my mind ten cases occurring in my private practice during the last seven or eight years, in whom the removal of the enormously swollen tubes would certainly have been justified, if I had not felt that it was my duty to endeavor to do all I could to obviate the necessity for the operation. One, a lady from Buffalo, consulted me eight years ago for as violent a salpingitis of both sides as I ever saw. She had an acute endometritis, her ovaries and tubes were bound down, her uterus absolutely immovable, the right appendages enlarged to the size of an orange, and I felt obliged to tell her that it would be impossible for me to cure her except by removing the appendages. She refused the operation, but insisted it being treated, no matter how severe the treatment was, so long as it benefited her and enabled her to live, without being operated upon, in comparative comfort. Her menstrual periods were profuse, the pain at times so severe as to require morphine, and had been so for years. I never knew a woman more persistent in her endeavors to regain health without the aid of a knife. Blisters, iodine, glycerin, hot sitz baths, hot douches, persistent local use of galvanism for months, finally succeeded in improving this case so materially that now the lady has been in very fair health for at least five years and has seldom been compelled to consult me or any other physician for her pelvic organs.

We frequently hear of cases where periodical discharges of so-called purulent material take place from the uterus, being preceded by pain in the ovarian regions. The assumption has been made, with fair justification, that these purulent accumulations came from a pyo-salpinx which filled and discharged and refilled and discharged again, but I am not at all sure that Bland Sutton is not correct when he says, in his recent work on the "Surgical Diseases of the Tube and Ovaries," that there is no trustworthy evidence that a pyo-salpinx or a hydro-salpinx discharges into the uterus. I, for my part, have never seen a case where an accom-

panying endometritis would not sufficiently explain the occurrence of the discharge. A case recently seen by me corroborates this statement. The patient had precisely the history of periodical purulent discharges preceded by pain in the ovarian regions which I have just mentioned. The diagnosis of pyo-salpinx had been made by Dr. Bache Emmet, who had her before me. He subsequently operated upon her in his service at the Woman's Hospital, and informed me that there was absolutely no trace of pus or suppuration in the tube.

I am sorry to say that, so far as actual cure is concerned, the palliative treatment referred to in the above lines is by no means as satisfactory as I could wish it to be. But I still feel that if by these remarks I can induce those of my colleagues, particularly the younger generation, who have not yet grown to believe that they know everything and that they are infallible, to be more conservative with the knife and to try to preserve to a woman her distinctive organs as long as possible, I shall feel amply repaid and able to endure with equanimity the criticism which undoubtedly I shall receive from some of the gentlemen referred to, with whom I do not agree.

DUCT PAPILLOMA OF THE BREAST.

In his Hunterian lecture (*Lancet*, July 9,) on "Certain Diseases of the Breast" Dr. Robinson refers thus to the above-named condition:

Duct Papilloma is characterized by the development of papillary growths in the larger ducts, usually in the region of the nipple, and particularly in the sinuses. There is no nipple retraction nor enlargement of the axillary glands. Discharge from the nipple, which may be serous, clear, or blood stained, or pure blood, is a marked feature, but is rarely persistent. The growth is unilateral, unaccompanied, as a rule, by pain or tenderness, and its progress is slow. It is met with in both the married and single from 35 to 55 years of age. The discharge from the nipple may precede any swelling by a considerable period. There may be a history of prolonged suckling, sore nipples or injury. On incising the swelling we have a space with smooth walls almost filled by a raspberry-like soft papilloma, attached by a slender pedicle. These papillomata may be single or multiple, usually the latter. Of these, one alone may be large; and they seem generally distributed in one duct area, of which the ducts may be dilated.

The following is an illustrative case. The patient, S. S., was a married woman, 39 years of age, the mother of three children, the youngest 15 months old, and still nursed at the breast. She had had cracked nipples, but no injury. On admission there was a lobulated and fluctuating lump just above and to the inner side of the left nipple, which was not retracted; this was first noticed three and a half years before, accompanied by a blood-stained nipple discharge and had grown without pain. The axillary glands were not enlarged. The right breast was healthy. On removal the small cyst contained a soft, purplish, villous papilloma growing from its deep surface and almost filling it, bathed by a yellow serous fluid; the growth was easily detached. The breast tissue around was indurated, and embedded in it were small cystic spaces containing greyish growths. The nipple was not removed. In about three months there was a reappearance of thickening at the base of the nipple, accompanied by some discharge. The nipple and all the diseased tissue were removed and since this time, for one year and a half, the patient has remained quite well. Rarely the warty growths may project from the mouths of the ducts on the surface of the nipple, looking like granulomata.

The papillomata are adeno-fibromatous in structure, composed of a delicate fibrous basis, on which are arranged one or more layers of epithelial cells, the deepest

being columnar in type. This connective tissue shows no cell infiltration. The cystic spaces are seen to be dilated ducts lined with cubical or short columnar epithelium continuous with the cell covering the papillomata. Specimen 4765 in the Hunterian Museum of the Royal College of Surgeons shows warty growths in enlarged ducts; at the exit of the chief dilated duct from the nipple there is seen to be a very definite constriction. In the case of S. S., before quoted, just beneath the surface epithelium of the nipple was noticed a small cavity filled with granular material. Below this the ducts passing down the nipple were dilated with small warty projections into their interior, and the glandular substance in a few spots seemed cystic. From these specimens the change in the ducts appears to be a generalized one and the papilloma only an overgrowth at a special spot of the changed duct surface. Is this alteration due to some obstruction at the nipple surface leading to dilatation and papillary formations behind this, as may happen with strictures elsewhere, or does the change occur in relation with the chronic irritation induced by prolonged suckling, or is the introduction of some irritant, mechanical or microparasite, the causal agent? To assume any of these is mere speculation, but the latter lends itself to our consideration when we remember analogous changes produced by such factors.

The diagnosis of these cases, from the discharge with thickening in the nipple region and no enlarged glands, is comparatively easy. The prognosis is good after removal of the diseased area if it is freely done. If only a small segment be excised, it is possible that some of the dilated ducts may be left behind, leading to reappearance of the growth. The affected area should be removed well into the base of the nipple for the same reason, if the latter be saved. The whole breast need not be taken away except in the cases where the papillomata are multiple and are not distributed in the same duct area. Many cases are recorded of permanent cure, and in no instance can I find a report of a recurrence of this condition as a carcinoma.

A SOURCE OF DANGER COMMONLY OVERLOOKED.

The Cincinnati *Lancet-Clinic* says:

Would it not be a good idea for Boards having such matters in charge to provide asphalt paving for all of the *alleys*? This would be a great sanitary achievement, for then they could be easily cleansed, and one prolific source of disease removed. We are convinced that our alleys do not receive sufficient attention from the authorities, and therefore they should be so constructed as to admit of ready cleaning. From a sanitary point of view our alleys are more important than the streets, because the latter will be kept clean, while the alleys are frequently reeking with filth, garbage and dead animals.

Medical Items.

A boil is like some men—it feels much larger than it is and is very annoying.

Dr. Claude Van Bibber and Miss Margaret C. Gilbert were married at Chester, New York, on June 15th.

A California quack makes the somewhat rash promise that he will pay half the funeral expenses in cases where he is "not successful."—*Medical Record.*

According to the *Revue Medico Pharmaceutique*, of Constantinople, the Turkish Government has decided to make vaccination compulsory throughout the Ottoman Empire.

Young lady patient: Doctor, what do you do when you burn your mouth with hot coffee?

Doctor: Swear.—*St. Louis Clinique.*

Œsipus, the crude fat from which lanoline is extracted, has come into use in dermatology. It is hard and has a bad odor, but the first objection can be overcome by adding sweet oil, and the second by some aromatic.—*Med. Record.*

Dr. Henry T. Formad, of Philadelphia, the distinguished expert in microscopy and toxicology, died June 10th, at the age of forty-five. He was a Russian by birth and was exiled on account of Nihilistic tendencies.

The classes in Yale College are subgraded according to scholarship, and it is found that in the first or best grade only twenty-two per cent. use tobacco; in the second grade, forty-eight per cent.; in the third grade, seventy per cent., and in the fourth or lowest, eighty-five per cent.—*St. Louis Clinique.*

It is believed that so-called "sun-stroke" begins in certain cases with disorder of the digestive secretions; or at least that the man with the disordered secretions will be the first to succumb. Let the citizen therefore watch over his digestion in the hot months as carefully as the mother guards her tender babe.

The Missouri State Medical Association has adopted resolutions condemning the practice, on the part of physicians, of giving certificates to manufacturers and proprietors of medicines, and also recommending to the profession the future discontinuance of such medicines.—*Boston Medical and Surgical Journal.*

The committee on foreign affairs have reported to Congress the bill to protect the insignia and name of the Red Cross. The bill incorporates the American National Association of the Red Cross, and describes the badge as a Greek red cross on a white ground. It is provided that it shall be unlawful for any person within the jurisdiction of the United States to use the symbol of the Red Cross as a trade-mark or otherwise, and imposes penalties for violation of the law.

Novelties in the suicide business have been plentiful enough of late. High jumps, ropes, pistols, poisons, and holes in the water will soon be out of fashion. Marguerite Borel has just introduced a new style *fin de siècle* beyond a doubt. Her faithless lover, Paul Convert, deserted her. Marguerite didn't want to live, so she purchased in different drug stores an immense stock of leeches. Then she went home to her nice little apartments in Boulevard de la Villette, Paris, where she undressed, liberated the leeches, and applied them all over her body. In other words, she modestly made an overcoat of them. Next morning she was found still alive and taken to the Lariboisière Hospital, where she died.—*N. Y. Sun.*

Mr. Garey, M. R. C. S., of Glasgow, who is a member of the Town Council of that city, is to be congratulated on having recently induced the Council to deal more liberally with members of the profession who are summoned to attend in cases of street accident. Hitherto the fee for such attendance has only been paid when the injured person was both able and willing to pay it, but in the future the city will pay a fee of five shillings in all cases of day accidents and ten shillings in night accidents; and this will be done whether the doctor be summoned by a police officer or by any other person. This arrangement must be regarded as fairly liberal on the part of the city authorities, in view of the fact that already there are specially appointed casualty surgeons receiving amongst them £460 a year and that the new system is altogether supplementary.—*Lancet.*

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CONTENTS

ORIGINAL ARTICLES.

Character, the True Test of the Physician. By J. W. Long, M. D., Randleman, N. C. . . 881

EDITORIAL.

On Graceful Retreating. 895

The Present Status of the Operation of Linear Craniectomy. 896

The Test of Character. 896

MEDICAL PROGRESS.

Evil Influences of Hot Vaginal Injections.—Operation for Wry-Neck.—Some Reasons for Daily Exercise.—A Case of Vesicular Vaginitis.—How to Use Peroxide of Hydrogen.—Going Barefoot in Search of Health. . . 897

THERAPEUTIC RECOMMENDATIONS. . . . 901

MEDICAL ITEMS. 902

Original Articles.

CHARACTER, THE TRUE TEST OF THE PHYSICIAN.*

BY J. W. LONG, M. D.,

Lecturer on Urinalysis in the School of Pharmacy, Trinity College, N. C.; Second Vice-President of the State Medical Society; Member of the Southern Surgical and Gynæcological Society; Secretary of the Randolph County Medical Society, etc.

Mr. President, Ladies and Gentlemen:—I count myself most happy to stand in this presence this evening, as, in some sense, the representative of the North Carolina Medical Society. That I have long coveted this honor, I shall not gainsay, but that I did not seek it, those who were foremost in electing me to be orator for 1892 will bear me out in saying. I have always believed and practised the maxim that "the place should seek the man."

It is an honor to represent our State Society at any time or place, and it gives me special pleasure to bear these relations before a Wilmington audience. The Cape Fear section has always been noted for its culture, hospitality and patriotism. Of its patriotism it may be said that, when on the 24th day of December, 1864, fifty-two federal war vessels ranged themselves in line of battle opposite Fort Fisher, and opened a bombardment unprecedented in the history of the world for its terrible energy and fury, throwing over twenty thousand shot and shell against the little fort in their futile attempt to reduce it—that under the intrepid Whiting and Lamb "even the boys were men in those days." Where men dared show themselves the junior reserves were to be found. There was no

*Being the Annual Oration delivered at Wilmington, N. C., in the hall of the Y. M. C. A. building, May 18th, 1892, before the Thirty-ninth Meeting of the North Carolina State Medical Society and the citizens of Wilmington.

shrinking with them, no faltering because of the trembling hand and weeping eye of the father and mother at home. No duty was neglected, no personal danger avoided, but with a firm trust in the goodness of God and the justice of their cause, those beardless boys stood forward in the hour of danger like men. 'Tis said the children of this city, boys from ten to fifteen years old, secured arms on that memorable Christmas eve, and patrolled the city all night long, guarding the prisoners, and keeping watch over their homes, that every available man might go to the rescue of Fisher. History can afford no greater instance of true heroism than the soldier boys of Wilmington. I am glad to look into the faces of a community which produces such boys as they.

Besides this, an acquaintance with the profession of the city, and a careful reading of the biographies of your physicians who have gone to their reward, convince me that Wilmington has been, and is, the birth-place and home of some of the grandest men that ever adorned our ranks.

Dr. Nathaniel Hill, educated in Edinburgh; Dr. James F. McRee, who had a wonderful brain, worked out the whole science of medicine of his day, cultivated botany and natural history, and brought together a great collection of choicest books; Dr. A. J. de Rosset, one of the first graduates at the University of Pennsylvania; Dr. James H. Dickson, the ripest scholar of his day, the first president of the Board of Medical Examiners, ex-president of the State Medical Society, who died at his post of yellow fever in the epidemic of 1862; and Dr. George William Thomas, who lived among you for thirty years, and laid his life down in trying to save that of a little child—were men whose works would perpetuate the fame of any city, and whose names will go down in the annals of our science as benefactors of mankind.

The position of orator, in a body like ours, is somewhat unique, in that the orator is expected to address a mixed audience, composed of both profession and laity. He cannot well choose a purely scientific subject, for fear the laity will not be interested, nor would it be in good taste for him to discuss a question strictly non-scientific, for then the profession would not be fairly represented. So that casting about between Scylla and Charybdis, the orator is often forced to write a shot-gun prescription, and endeavor to meet all indications in the same dose. On a similar occasion, I undertook to find a subject in which both profession and laity were alike interested, but after much research could find nothing in which they had a mutual interest except doctors' bills. Even in this matter, I found they were very much divided—the profession acting strongly like the prosecutor, while the laity decided with the defendant.

However, a more extended experience and observation have taught me that the most vital point of interest between the profession and the laity—between the doctor and the patient, is the *character* of each. The greatest point of difference in this particular is, as I see it, that the patient can choose what kind of a character he will have for his physician, while the physician has very little if any choice as to the character of the patients he will attend. You may say, "it matters not what kind of a character a patient has, just so the doctor gets his fee." I grant your assertion. If a doctor is going about simply to glean dollars, it makes little difference to him whether those dollars come from an honest man, or a highwayman. But I am not representing that kind of a doctor. Besides, a doctor is not a mere machine, nor do patients always pay cash—*i. e.*, up in Randolph—of course they do in Wilmington. Again, a physician's success depends so much upon the result and influence of each individual case, that every case must be considered a link in the chain of his success. A doctor may have two cases

exactly alike as to cause, symptoms, pathology, etc., yet a moment's reflection will convince us that the outcome of these two cases, to the physician, will be widely different. One patient will be grateful, gracious, pay his bill promptly, say he thinks you charged him very reasonably, and never ceases telling his friends how successfully you treated him. While the other fellow will complain all the time that he is getting no better, that your medicine don't act right, that Dr. Jones gave him something one time which was just the thing he needed, that he would have been up now had you treated him differently, and when you come to present your bill, "My, my! Why, doctor, you did not come to see me that many times. I did not know you charged extra for coming at night, or for staying all night." Then he puts you off with a promise to "pay you soon," which generally means *no pay at all*, but he will be exceedingly careful to tell every body he sees "how mean you acted."

Think a doctor don't care what kind of a character his patient has? I advise those of you who think that way to try practising medicine a while.

Now as to the doctor. There are many standards by which we may estimate a physician, but the true test by which a physician should be judged is his character. Give me a young man's character, and I can tell you what success he will score in after-life. Give me a doctor's character, and I can tell you how he will apply the great principles of our noble science. Give me his character, and I can tell you how he will meet the oft-recurring emergencies in the practice. Give me his character, and I can tell you how he will treat his patients and the public generally. Give me his character, and I can tell you whether he practises medicine for the sordid love of money, or because he believes his life-work to be a high and holy calling, and he goes forth in the name and spirit of Him who went about the sorrowing wards of this world, casting light into darkness, speaking peace to the troubled, hope to the down-trodden, sight to the blind, music to the ears of the deaf, health to the lame and sick, life to the dead, reason to the maniac, and pardon to the guilty.

You ask me "what is character?" I reply, character is what a man really is —'tis the man. The word "character" primarily means a scratch, or sign, or stamp—a distinctive mark whereby an engraver, or other worker, marks his work as his own. Its use goes back to the days when every brick manufactured on the plains of Shinar, or by the banks of the Nile, received its graven image designating the ruler by whose order that brick was made.

As applied to a person, the word "character" is used in several senses, but primarily it means *personality* or *individuality*, and in that sense we will use it this evening.

Character, then, is that quality which *marks* a man—which distinguishes him from the mass of mankind. There are certain qualities which are common to men, possessed by all. They, of course, do not mark a man's individual character, for they are no more one man's than another's. A great many persons have nothing or next to nothing—either by birth or acquirement—which distinguishes them from the common herd. Hence, such persons are said to have no character, or very little character. On the other hand, there are persons of strong individuality, who are themselves. They think for themselves, act by themselves. They have their own convictions, their own purposes, their own personality. Such persons have character. The tendency of the average man is to do as others do, eat what others eat, drink what others drink, wear what others wear, go where others go. Such a man has nothing to mark or to distinguish him. I would not have you think that obstinacy or eccentricity is character, for they are not,

Obstinacy is mulish, and eccentricities are superficial. Personality, not singularity, is what indicates the man. God reliant, hell-defiant, and man-resistant personality is the basis of all true character. And just here let us make a sharp distinction between character and reputation. Reputation is what the world says about a man, character is what the man really is. They may be the same, they often are not. This is, perhaps, more distinctively true of physicians than any other class. Take, for instance, the matter of professional ability. Put the question to yourselves. How often have you been praised and credited for abilities you do not possess? On the other hand, how many hundred times have you been disparaged and your abilities underrated to that degree, that if what "they say" about you were true, you ought to be kicked out of the profession. My brother, what your over-zealous friends say about you, on the one hand, and your enemies say, on the other, is only your reputation, and does not affect the issue of this hour. Why, there are people up in my county who would not trust me to prescribe for a simple colic, while there are those who believe I could put a new floor in the fourth ventricle. It is not what the people say about a man, it is what the man really is, that constitutes character. Sam Jones says, "We may know a man by what his neighbors say about him." If that is true, and I think it generally is, some of you doctors are pretty hard cases. But granting the entire truth of what Mr. Jones says, it by no means follows that what a man's neighbors say about him is always true. What they say may be a good basis from which to form an estimate of the man's character, but they may be wholly in error. For instance, his neighbors may say, "He is close, stingy, mean, a veritable Shylock." When the truth is, he is only scrupulously honest and exact. They may say, "He is such a pleasant, agreeable fellow, not even raising a fuss with anybody," when the truth is, he is a miserable sycophant, currying favor with everybody he meets, and without backbone enough to have an opinion of his own. True, these instances are what J. Stewart Mill would call "fallacies of observation," but "these fallacies are peculiar to the mass of mankind." Especially is the public liable to fall into these fallacies in its estimate of a physician's abilities. They estimate a doctor by his style, his manner, by the amount of *Ego* he can judiciously compress into his conversation, and largely by his (apparent) success. Again, public opinion, unlike character, is very capricious, and shifting as the sands of the sea. The popular favorite of to-day may by one failure become the subject of derision on the morrow, while one signally successful case may win the plaudits of the populace. But all this goes for naught when we come to judge a man by the standard we raise to-night. As reputation may be compared to the sands of the sea, at the mercy of every ebb and flow of the restless tide, so character may be compared to the mighty rock standing boldly out from the shore, immovably fixed upon the very foundations of old mother earth, and upon which the sciences, and the religions, and every great enterprise, love to build their light-houses of eternal truth, rescuing the unfortunate and guiding those who would press forward. He who builds upon such a foundation shall never be moved, no matter what calamity overtakes him or what opposition confronts him. When Stephen of Colonna was taken captive his enemies asked him in derision, "Where now is your strong fortress?" "In here," he boldly proclaimed, placing his hand on his heart.

Character, what is it? It is the *ruling principle* of a man's life, the *well-spring* of his existence. It is the standard by which he himself shapes and governs all his actions. It is that which makes him magnanimous, and brave, and charitable; true to his convictions, in every sphere of life. Let me illustrate:

An officer in the American army married a northern lady, who, coming home on one occasion from a visit to Canada, smuggled through some dress patterns without paying the custom-house duty on them. Reaching home, she boasted of her exploit to her husband, who immediately sat down and inclosed fifty dollars to the custom-house officials, saying he could not cheat the government he served out of it's just dues. I shall ever be proud to hear that man's name. Just after the war, while a wee bit of a boy, I sat one Sunday afternoon on the front porch with my mother, who was then a young widow. A negro man came in and offered her a roll of greenbacks, saying it was for a cow he had recently bought of her. She quietly but firmly refused to receive the money because it was Sunday. The man insisted, saying he might not offer it again, but she told him she would rather lose the money than to violate the Sabbath. That's what I call character.

But you ask me, "How may we know a doctor's character?" I will give only a few, which, however, may be called the cardinal principles of every true physician's life. Let us consider first the things he does *not* do.

I. He does not advertise. This is an age of advertisement. The wonderful enterprise and restless energy of the newspaper man have convinced the public that the only way to do business is to advertise. Into this seductive vortex, many a doctor, anxious to catch the public eye, has been drawn. A young friend of mine went before the examining board for license. He wrote back to me, "I came through with flying colors. If you think I deserve a little puff, please put one in the county paper for me and I will appreciate it." (Of course he would). I replied to him, "not to be so modest; if he wanted to advertise, have some large posters printed and stuck up at every cross road, or start a paper and call it The Medical News. For quacks didn't do things by halves, and if he was determined to be a quack, be full-blooded." I am glad to add that this young man, who is really a worthy young fellow, thanked me heartily for the timely admonition, and has never since attempted to advertise, but, instead, has gone to work and built up a splendid practice.

No true doctor will allow a friendly editor to give him too many gratuitous personal notices in his paper. But there are other ways of advertising, besides puffs and big head-lines in the newspaper. For instance, here is a sample; I picked this up at a public hotel:

"T. Timothy Tadlock, M. D., Physician and Surgeon, having removed from Huckleberry town to the valley of Break-bone Fever, offers his professional services to the people of Measleville and the surrounding country.

"I am a graduate of the College of Physicians and Surgeons, Baltimore, Md., and a licentiate of the North Carolina Board of Medical Examiners.

"Diseases of women and children a specialty. Charges reasonable. All calls answered promptly day or night. T. Timothy Tadlock, M. D."

These fellows always follow their names with a big "M. D., Physician and Surgeon." That is, they are "doctor," as a matter of course, then their title would indicate that they are "doctorem in arte medendi," and, added to these, they are both "physician and surgeon." And I never saw one of them who did not make a "specialty of diseases of women and children."

I have given you an actual case, and, what is worse, "T. Timothy Tadlock, M. D., Physician and Surgeon," is a member of the North Carolina Medical Society.

My, my! How it makes my "blood boil" to see a man who ought to know better prostituting the high and holy calling of medicine to the level of a huckster.

Perhaps the most adroit and taking way for a doctor to advertise himself is to

"blow your own horn, Billy," for in many instances "he that bloweth not his own horn, the same shall not be blown." He must drive very fast, always be in a big hurry, look wise, assume an air of importance, as if the fate of a nation hung upon his words and deeds. Ask him about his practice, and he will say, "I am riding day and night; I haven't slept any for three or four nights;" and I have known some of them to go without eating or sleeping longer than Tanner fasted. But listen to the prodigy: "I travelled 20" (some say 30, some 40) "miles yesterday. I have prescribed for twenty-five or thirty patients to-day. I am making from $15 to $250 every day" (of course he doesn't refer to the fact that his current expenses for the last month are not paid). Now *we* know that he is *lying*, and *he* knows that he is lying, but let's not be too hard on the young man: he is simply *advertising*, and somebody will believe him, especially the old women and the "niggers and poor white trash," who will repeat what the young Æsculapius hath said, with numerous variations and additions.

Now, all this is bad enough in a young blood, just home from college with the odor of the dissecting room still on his fingers, and his ideal professor before his eyes, but to see an old man try to boost himself by such miserable subterfuges is detestable beyond comparison. I don't suppose any doctor in this audience ever advertised. Oh, no!

II. No true doctor ever endorses quacks or quack-remedies. Ever since the days when the priesthood and medicine-man were combined in one, and he had to take the Hyppocratic oath to divulge no secret intrusted in him, medicine has furnished a vast and fertile field for humbuggery and charlatanism. The shadows of the superstitions of the dark ages seem yet to linger upon the mind of the public, and like Banquo's ghost, "will not down." I have but to mention Perkinism, to remind you how the popular mind has been swayed and deluded by a "will o' the wisp," by which hundreds of thousands were treated and many even cured, by the simple application of two metal or wooden tractors without the presence or semblance of a battery. I need name only a few of the patent medicines flooding the country to-day to recall the faith which the public places in quack remedies. Baby lulled to sleep with "Mother Winslow's Soothing Syrup;" Mary's headache cured with "Bradycrotine;" Sammy's rheumatism rubbed out with "Perry Davis' Pain Killer;" Mr. Dude's blood renovated by "S. S. S.;" the old man gets too lazy to work, has the chronic headache, and flies to "Warner' Safe Kidney Cure" for relief; and mother, poor old soul, she's broken down waiting on this complaining family, and, as a matter of course, resorts to "Pierce's Favorite Prescription." The only ingredients necessary to make a patent medicine are a few bitter herbs and a heap of mean whiskey; and the only condition necessary to sell it are a fraud for a vender and a fool for a buyer.

I repeat it, that no true physician will ever endorse these vile nostrums; and more, he will never lose an opportunity to expose them to the public. I made a talk along this line on one occasion before our County Medical Society, at the close of which an eminent lawyer came to me and said, "You are right, doctor; the people cannot be expected to know better concerning these things until the profession teaches them." In the highest sense of the word, the physician is the guardian of the people's health, and for him to endorse, or prescribe, or sell these cure-all remedies, or to send confiding patients to traveling opticians or dealers in glasses, to have their errors of refractions corrected, is to be false to his trust in every sense of the word. Your practice may have attained such magnificent proportions that you can afford to lose these cases, but you are false to your pa-

tient and to the public who believe in you, false to your neighbor who is an expert oculist, and false to the profession whose escutcheon you have lowered and trailed in the dirt of ignorance and superstition.

III. There is another distinguishing trait between the true and false physician, the man of character and the man who lacks it. I know no better name for it than *rascality*. The physician who percusses a slightly congested lung or irritable heart, gives an unfavorable prognosis, and prescribes a nauseating mixture, is, nine times out of ten, an impostor. The physician who "just does" get to his patient in time to save his life, who is always "breaking up the fever," whose patients would have had pneumonia had they not sent for him "just when they did," is a fit subject for the inside of the penitentiary. The physician who is always "rushed to death" with his patients, who is always finding and removing tumors, who magnifies simple examinations, which his neighbors are doing silently and skilfully every day, into big operations, and whose praise is constantly in the mouth of all the wise old women in the neighborhood, ought to be kicked out of the profession. I say *pulverize* such fellows.

IV. Again, the true physician never *unjustly criticises his brother physicians*. Why, do you know the envyings and jealousies and backbitings we sometimes indulge in have come to make us the by-word and ridicule of every one? Brethren, these things ought not be.

Mr. Bayard Taylor, in one of his books of travel, gives the following incident: Calling at a house to ask concerning his way, a large, vicious, brutish-looking man came out and gave him the desired information. Mr. Taylor afterwards learned that this man was one Keysburg, the only surviving member of a party which a few years before was overtaken in the mountains by the winter snow. When rescued in the spring, this man only was found alive, and he was sitting by a fire over which hung a pot containing the boiling flesh of some of his dead comrades. His face and hands were smeared with blood and grease, and so ravenous was he for the human flesh, that it was by great force they could drag him away. Near by lay the frozen body of a dead ox, which, however, was not so tempting to Keysburg as the flesh of his dead companions. Now, I know doctors who *seem* to live by abusing other doctors. You can spot one of them as soon as he opens his mouth. His first word is a slur at somebody. He will talk about nothing else. And you can hardly drag him away to some more wholesome subject. Although he be surrounded by a whole world of science, and unsolved problems, yet nothing is so attractive to him as the life-blood of some fellow laborer. I say, *away* with such cannibals.

These are some of the *negative qualities* of the physician of character. Now let us notice a few of the *positive* traits:

I. First and foremost among the jewels which cluster around this matchless word "character," is that quality known as *decision*, decision of character—the power to decide. Without this quality the noblest character would have little effect. According to the inspired writer, even the blessings of heaven are withheld from a man who lacks decision of character. "He that wavereth is like the wave of the sea, driven of the wind and tossed. Let not that man think he shall receive anything of the Lord." (James I, 6-7.)

There are ten thousand questions arising in every physician's practice, upon which hangs the health and life of some confiding patient. Of course, any old woman in the neighborhood could quickly and easily tell what should be done, and she knows to a dead certainty whether or not you treat the case right, but the conscientious man hesitates, and weighs well the merits and issues of the case

before deciding. How often I have been shocked and disgusted at hearing a doctor dismiss a case by saying, "O, pshaw, he's nothing but a nigger, anyway," or, "It's only a baby dead; it's better off."

Take a case of acute intestinal obstruction, call in two or three or four physicians, and let them consult over the case. Just listen to them. One says, "I would give broken doses of calomel, followed by castor oil." Another says, "I would give opium and apply poultices." The third man says, "There is an acute obstruction: calomel and oil will only aggravate, opium and poultices will cover up and mask the symptoms, so the only rational way is to operate, overcome the obstruction, and give the patient a chance to get well." Doctors disagree, family physician called in to decide. He says, "Wait till to-morrow." Result: A first-class funeral. Now, only one out of four had any decision about him; the rest said, "Wait, do something else," and then let the man die.

When Dr. Edward Warren, a North Carolina doctor, was in Egypt, the Khedive was seized with strangulated hernia. The native physicians could not relieve him; they were afraid to try any rational method. Dr. Warren was called in, saw the man's extreme condition and decided at once what should be done, and that quickly. The native doctors fell back and excused themselves from further responsibility in the case. Dr. Warren went ahead, operated, and saved the old Khedive's life. This failure to decide has cost many a valuable life, has robbed many a household of its brightest flower, or of its stay and comforter. This question, what to do, and when to do it, has cost every conscientious physician many and many an anxious hour. But if he is a man of character, you may be sure that when he does decide, his decision will be the very best thing that can be done for you.

II. The physician of character has the courage of his convictions. This is an easy matter when the majority are on your side, but when you are in the minority of one, as I have often found myself, it is no small thing to "speak out in meetin'." A physician is called to see a medical case; he sees at once it is a surgical case, and to save the man's life something must be done promptly. He knows full well that the bare mention of an operation will terrify the patient and set the whole family in an uproar. Oh, yes, I have been there. He also knows further, that if the patient refuses an operation and should get well in spite of his desperate condition, that he will never do any more practice in that neighborhood. To speak out your convictions under such circumstances requires courage.

There is another point where I have seen doctors break down and prove false to their convictions. That is in regard to drinking. There are physicians who attend our annual conventions who would not for the world be seen drinking wine or champagne at home, yea, who are stewards, and deacons, and elders in their church, yet they march into these so-called banquets just like "little men" and drink like "big Injun." Do they think it is right? No. Their conscience says "No." And if they had the courage of their convictions they would not do it. May God speed the day when these wine suppers and champagne receptions shall be banished from our annual meetings.

The true physician has the courage of his convictions in spite of all opposition. You know the same gust of wind which blows out a lighted taper will only fan a larger flame into a big fire, if there be fuel enough. When in 1847 Semmelweis made the startling announcement that puerperal fever is a septic process due to infection from without, he set himself up against the accepted doctrine of twenty centuries, and brought down upon his head the ridicule, and derision,

and scorn, of the entire profession. Nor did the persecution let up, but continued through many years, to the close of life, when he died unhonored and unsung. Through it all Semmelweis remained true to his convictions, hanging on with fanatical persistency, and to-day no intelligent physician can be found who does not believe in the Semmelweis theory. Harvey was opposed by the entire profession for proclaiming the circulation of the blood. And I want to say it was the christian ministry, and not the profession, who upheld and encouraged Harvey. Jenner is another well-known instance, where a man against formidable opposition was true to his convictions and finally triumphed.

In 1809 there was in McDowell County, Kentucky, an humble physician, to whom a woman came sixty miles on horse-back and asked him to remove an enormous tumor. He requested several of his neighboring physicians to assist him, but "they all with one consent began to make excuse." Nothing daunting, he appointed a day and began the operation. The matter had been noised abroad, and a large crowd of excited people had collected around the doctor's little office. The sheriff of the county happening by, inquired, "Why all this tumult—are the Indians about? (Kentucky was then a frontier State). "No, no," exclaimed the mob, "worse than the Indians; there is a man in there about to kill a woman." The sheriff, after further inquiry, said to them, "Let us wait, and see if he kills her; if he does not, all well and good; if he does I have nothing further to say." When Jesus Christ left the glories of his Father's mansion and came to save a dying world, they went by night, took him with staves and brought him before Pilate, and when Pilate took water and washed his hands in the presence of the multitude, saying, "I find no fault in him," they cried out all the more, "Crucify him, crucify him." And when Ephraim McDowell took his scalpel in hand, intent only on saving the life of that poor trembling woman, who lay upon his table with no anæsthetic save her faith in her doctor, the angry, tumultous, excited mob surged around his office and cried out aloud for his blood. Thanks be unto Him who hath said, "Only be thou strong and very courageous, that thou mayst prosper whithersoever thou goest" (Jos. I, 7), that while they did crucify our Lord and Saviour, he arose again and through him we have eternal life, and that while Ephraim McDowell was hooted and persecuted and threatened, he stood firm, and though dead he yet liveth and speaketh to us to-night, and through that day's work over 800,000 years have already been added to the life of woman.

III. Another unfailing mark of a true physician is *applicating* energy of purpose. I do not refer to the mere practice of medicine. A man may be prompt and energetic in visiting his patients, and while this is commendable, yet he may do it purely for the dollars he earns, and at the same time be the merest tyro and drone in the science of medicine. The profession of medicine rises above this. Medicine is a science; the art or practice of it is only its application to the needs of humanity. Again, while medicine is a science, it is not yet an exact science. And no man can sit down and say, "I know it all; I have no need for further study; I fall back on my own experience to guide me." My, my! "Upon what meat hath this, our Cæsar, fed that he hath grown so tall?" Our doctors do not read and study enough, they don't buy new books and periodicals as they should, nor attend post-graduate courses; they get into grooves, a routine practice; and, as a matter of course, their patients die by routine. Why, I have heard some say, "O, well, a doctor don't need but one course of lectures to practice in this community; now, if I was in a

city I would take another course." Isn't that a pitiable sight, to see a man take the issues of life and death in his hands, and hear him say, "Human life isn't worth enough in this community to justify me taking another course of lectures."

I congratulate the people of North Carolina that our State Medical Society, ably seconded by its legitimate offspring, the Board of Medical Examiners, is fast starving out this class of doctors, and saying to the future doctors, "Come up higher or stay outside." Young men, the finger of science points steadily in one direction—forwards. Nor does it lead down by loafer's corner; nor sluggard's couch; nor by the saloon, nor brothel; nor is your progress in that direction accelerated by sparkling champagne, or the wine which "moveth itself aright." There is an unwritten obligation laid upon every man who espouses the science of medicine, to wit, that he will bend *every energy* he possesses to *perfect* himself for the duties of his work. A clear and comprehensive knowledge of the problems which confront us on every hand is too obvious to remark, yet I doubt if any of us were sufficiently sensible of it until some sudden emergency stared us in the face. Was it a torrent of life-blood? Or was it the necessity of a resection? Or possibly the sudden stopping of the heart under anæsthesia? What pain and awful fear seizes us? O, for light just at this moment on this particular question. What would we give for just ten minutes perusal of our favorite author. We look around for information, eagerly and anxiously, as a benighted wanderer looks for the light of a human dwelling. Yea, only *one word* of assurance from some man who *knows* would be as refreshing as the tip of Lazarus' moistened finger would have been to the parched tongue of Dives. My brother, there is no need of you and I ever being overtaken by such calamity. The sovereignty of labor is nowhere better exemplified than in the *study of medicine*. There is no surer road to success than through your books, your experiments, your laboratories. Emergencies—which are nothing but grand golden opportunities—come to every man, yea, they are on us all the time. If we would make the most of them, we must prepare to meet them, and there is no surer mark of royal blood which flows through every true physician's veins than that he is indefatigable in the study of medicine. This involves immense energy. I like the spirit of the old Norseman whose crest was a pickaxe with the motto: "Either I will find a way or make one."

Energy enables a man to force his way through irksome drudgery and dry details, and carries him onward and upward in every station of life. It accomplishes far more than genius with not half the disappointment. Hence energy of will is called the very central power of character in a man—in a word, it is the man himself. It gives impulse to every action, and soul to every effort. It is will-force of purpose that enables a man to do or be whatever he sets his mind on doing or being. More, intensity of purpose never fails to bring its sure reward. I never spent an hour in hard study in my life that I did not get ten honors for it. I never bent my whole energies on any subject that I was not credited for more than I knew, so productive is a little effort wisely expended. The scriptural injunction is, "whatsoever thy hand findeth to do, do it with thy might."

IV. The last distinguishing trait of the true physician which I shall notice is, that he is a full-rounded christian gentleman. In saying this, I would close my eyes to all denominational and doctrinal lines. I care not whether a man be a Methodist, or Baptist, Armenian, or Calvinist, or Protestant, or Romanist, Jew or Gentile, but he must acknowledge allegiance to Him who "spake as man never spake," who made the lame leap for joy, the dumb to shout for gladness, and the sick man to "take up his bed and walk." But you say, "There are plenty of

physicians who have risen to eminence, yet make no pretensions to christianity, but are outspoken sinners." That is true. On the other hand, for every bad man who has ever succeeded as a physician, I can point you to ten christian doctors who are his superiors. Again, whatever measure of success an unrighteous man may have, he falls far short of what he might have accomplished as a christian. In his arraignment of Warren Hastings, Edmund Burke said, "I never knew a bad man that was fit for service that was good. There is always some disqualifying ingredient mixing and spoiling the compound. The man seems paralytic on that side. His muscles there have lost their very tone and character —they cannot move. In short, the accomplishment of any thing good is a physical impossibility for such a man." And this is only another way of putting what Solomon said, in his wisest mood, "as he thinketh in his heart so is he," as a man is in his inner self, in his moral nature, so he will be in his outer self, in his practical exhibit of self, in conduct.

A moral purpose, a controlling moral conviction, gives added force to the words and actions of any man in any sphere. It is not that he has no power without it. It is not that he can never appear to advantage with its lack. But it is, that its possession gives increased potency to his work, secures trustworthiness to his endeavors and the confidence of the people. You feel the moral purpose of the man in the very thing he does or says. How it thrills in his writings, how it sounds out in spoken words. You cannot have an abiding confidence in a minister or a lawyer whose morals you distrust. Would you apply a lower standard to the man in whose hands you place your life and that of your family, to whom you must confess the innermost secrets of your heart? Nay, verily, to do so is to lean upon a "bruised reed."

And I want to say that one of the very best tests of a man's christian character is his *faith in the power of prayer*. You know when "Asa fell sick with a disease in his feet, he sought not the Lord, but the physician." And the next verse adds, "Asa slept with his fathers." In Jer. XVII, 5, we find these words: "Cursed be the man that trusteth in man, who maketh flesh his arm, and whose heart departeth from the Lord."

Now, I have no patience with this so-called "Christian Science"—when they ignore the very means God has given us with which to heal our infirmities, and sit around expecting Him to work a miracle in answer to their prayers. "Heaven helps those who help themselves" is as true in medicine as anything else. I believe in the power of prayer, but when I have a case of empyæma, for instance, I do not ask God to cure the patient, and then sit down expecting Him to absorb a half gallon of pus; but I get down on my knees and ask Him to show me what to do, then I get up and take my scalpel and go to work, and I verily believe that if God wanted me to stop, He would send an angel to stay my hand, as when Abraham lifted the gleaming steel above his darling boy. Yes, I believe in the power of prayer, and I would not offer homage to any deity who would not help me in the hour of need. I am so glad that when Ephraim McDowell laid his patient upon the table and while the mob clamored for his life, he went into an inner room and getting down on his knees offered a short prayer. It seems to me as I stand in this presence to-night, that I can almost catch the echo of that petition, reverberating down the corridors of seventy-four years, as with a pure heart and holy hand he lifts his face heavenward and says: "O God, give me, I pray thee, this woman's life for my hire." When Hezekiah turned his face to the wall and prayed, God added fifteen years to his life, and to McDowell's

woman he gave thirteen. Yea, more: in answer to that prayer, God has added on an average ten years to the life of every woman submitting to ovariotomy.

Brethren, as I stand here as your mouthpiece, I stand tearfully but fearlessly. Would you know why? Away up in Randolph, there is, at the old homestead, in her room, on her knees, at this very hour, a precious old mother, beseeching a throne of grace to bless her boy and help him speak forth words of truth and soberness. And let me tell you, young men, when I get beyond my mothers' prayers, and her old Bible, and her God, I shall move out from this country, to some distant planet and run a little world after my own conceited style.

Thus far, I have addressed myself specially to the individual. Now let us consider briefly the profession taken as a whole. Consider for a moment our State Medical Society, composed of over four hundred of the very pick and choice out of two thousand physicians living in the State. What a tremendous power for good or evil the organization carries in its grasp. As the government of a nation is but the reflex of the individuals composing it, so is the influence of a society like ours but the expression of the individual character of its members. We are accustomed to decry great social evils, where in truth they are but the outgrowth of our own perverted lives. We, as a society, meet in some town, and the physicians there, as a body, tender us a so-called banquet. We go as a society, get more or less drunk as a society, and the next day in convention assembled offer a motion of thanks for the "kind and generous hospitality" which made us drunk. O, my brother, can you lose sight of your individual responsibility for your conduct in this matter? Does your brain become so befuddled with Roman punch that you can't tell whether you are yourself or someone else? But I hear some of you young fellows say, "This is the only chance I have to drink champagne and wine." That's true, for when you are at home, you drink corn whiskey at twenty-five cents a pint. You ride on a seven dollar cart or a three dollar saddle all the year 'round, and come up to these annual gatherings expecting to drink "extra-dry," at somebody else's expense. You are a disgrace to the profession. "O," but you say, "I get a good practice all the same." Yes, the public are very lenient towards you, they know you are a miserable old drunkard, and can't help it, and then they say, "You are the best doctor in the neighborhood, when you are sober," and they say, "You won't give medicine when you are drinking," but you know you prescribe every chance you get. These so-called banquets have come to be a nuisance and a term of reproach to the profession. And if we keep this thing up much longer our legislature will be for enacting a law like the one in Georgia, which prevents a physician from ever practising again after having been convicted of drunkenness. I am so glad there are physicians in the grand old city of Wilmington, who, while they throw wide open their homes and hearts to receive us and makes us enjoy our visit here, have the moral courage to say, "No one shall get drunk at our expense." I say, "Hurrah, for these men, than whom there are none nobler, wiser or more gracious." The aftermath of their example shall be as sweet as a sweet-smelling savor, more delightful than the odor of new-mown hay, more far-reaching in its significance than a hundred sermons or a thousand formal protests, such is the power of right living. Let me commend their example to the town where we go next year, and the years to come, as worthy of emulation. But if you will have a banquet, do be as considerate as our Asheville brethren, who gave their banquet the night *after* adjournment and *forty miles away* from the place where the society met, so that those of us who felt under no obligation to get drunk had a chance to get started home.

Who is responsible for these things? Every one who takes any part in them. First, and foremost, I want to say to these old men, "You who are the leading lights in the profession and the pillars of the society, and whom I address reverently yet fearlessly, I charge *you* with helping by your example and influence to spoil the flower of our young manhood in its very bud. Young men come here for their first time, and seeing you indulge in these things, hearing *your* peals of laughter at the popping of champagne corks, say, "Surely if men of such standing and confessed goodness as these indulge in these things, it can be no harm for me to take just a glass or two."

Now some little fellow who always writes a big M. D., after his name (and this reminds me that possibly he is the fellow whose grandfather was a monkey, and the M. D. is intended to signify "descendant of a monkey"), will say, "Long is slandering the profession." I deny the charge. I yield to no man the precedence in admiration and love for the profession. I rejoice that I sprang from the loins of a man who spent his life, yea, who gave his life, in the relief of suffering humanity. And while he left me neither prestige of aristocracy, nor heritage of money or lands, yet by his life he instilled into my heart the desire to succor those in sickness and distress, that I would not exchange for wealth, nor royal titles, nor bluest blood that ever ran. Peace to his ashes and honor to his memory. Of the *old* men in the profession, I am especially fond. All along some of them have been indissolubly linked with my career. My preceptor an elderly man, my first partner an old man, my second partner an old man, and I can never forget that, when in my earlier experiences I lost two surgical cases within a week, it was an old man who quit his immediate practice, and rode many miles to my relief. It seemed the very heavens would close down around me, and I said, "I will throw up the sponge and quit." Then this dear old man put his hand on my shoulder and said, "My son, do not talk that way; you are all right; just press forward." If it had not been for the old men I could not have stood where I do to-night. I go further, and say, we young men should not be too anxious to lay these old men on the shelf. Many of them have served their day and generation and done it well. One by one they drop out of the ranks. Every year some of them who were with us the year before fail to answer at roll call. This year it was the sweet-spirited Beall, the cultured Aske, the fearless surgeon, Budd; last year it was the untiring McDonald; and so the list grows. These old men, the *pioneers* of medicine, and the workmen who need not to be ashamed. When you and I were in swaddling clothes, or perchance our eyes had not seen the light of day, they were struggling to elucidate the science of medicine and establish the practice upon a firm basis. They had to contend with the very powers of darkness, ignorance, superstition, witchcraft, prejudice, powers which combined make a gloom more dense, more impenetrable, and emitting more deadly miasmata than the tropical forests of "Darkest Africa," through which Stanley wandered and literally hewed his way for so many weeks and months without ever seeing the sun. May God bless the old men.

But with all that, I want to say to the young men of the profession, there is no need that we perpetuate the errors of our fathers. I would rather have the gratitude of my son than the approbation of my father. My father may have been in error, my son will know whether or not I am wrong. The future of our society rests not with these old men, but with you. Brethren, let us be men. I like the spirit of my little boy's reply when asked if he was going to be a doctor, "O no, I am going to be a *man*." The little fellow had caught the idea

that to be a doctor does not always mean to be a man. (Probably the effect of home influence.)

"This above all, to thine own self be true.
And it must follow, as the night the day,
Thou canst not then be false to any man."

We have passed in rapid review some of the distinguishing marks of the physician's character. Those which are conspicuous by their absence are advertising, charlatanism, rascality, unjust criticisms, drunkenness. That these are characteristics of bad men and are opposed to all real progress there can be no question, and it is equally true that all of these vices may be largely eliminated from our ranks. But to do it, we must be stalwart men, thoroughly grounded in the essentials of a true character. When the Persian youth learned to tell the truth, keep a secret, and draw the bow, they over-ran all Greece. When our doctors learn the full force of character as applied to the physician, when they learn to eschew evil and choose good, when they learn to draw the bow of scientific accuracy instead of depending upon routine, haphazard methods—then, and not till then, will this grand old ship of science—our profession—be freed from the slimy arms of the loathsome octopi which seek to drag her beneath the chilly waves of ignorance and superstition, and feed upon the life-blood of every man, woman and child entrusted to her care.

I have endeavored to show you that the true physician, the true friend of science, the true guardian of people's health, is he whose character is founded and built upon the rock of *eternal truth*. That he is distinguished by decision of character, the courage of his convictions, intense energy of purpose, the graces of a christian gentleman, and an abiding faith in the mercies of God. Is the grand old ship of which I just spoke manned by such men as this? Let us see. Upon the bow of this magnificent vessel, with her heaving engines, electric lights, polished sides, elegant appointments, matchless record, and untold possibilities, I see emblazoned in golden letters that magic word—*Character*. Upon the insignia of the commanding officer I see the one word—*Character*. Upon the cap of every subaltern I see the word—*Character*. I turn to the men, and looking into their faces I see as in a mirror of their hearts—*Character*. *Character* is in every command. *Character* is in every turn of the pilot's wheel. *Character* is everywhere. Sail on, lovely mistress of the sea, we cannot doubt thee. We fear for thee neither wind nor wave. The *Character* which thou art shall protect thee, and while thine enemies may detract, while the storm may rage, and the billows break over thee, we know thou wilt *roll on*, in spite of all opposition, until thou hast carried thy precious cargo of human health and life within the haven of safety.

Druid Hill Park is holding its own as one the most beautiful breathing-spots for tired humanity to be found in any portion of the world. And the people of Baltimore are not slow to avail themselves of the shelter of its great oak trees. Groups of visitors with lunch-baskets dot its grassy slopes, and here and there a tired mother will be found under some shade-tree fanning her sick infant, as it finds on nature's soft green couch the first sound and refreshing sleep for some days.

Baltimore has a new health resort, within reach of everyone, even the poorest, and always furnished with a cooling breeze. We refer, of course, to the cable-car.

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BALTIMORE, AUGUST 6, 1892.

Editorial.

ON GRACEFUL RETREATING.

Among the many practical lessons that are not taught in the schools is that of retiring in good order when vanquished at any point in a therapeutic contest against disease. Every young physician is at times humiliated almost beyond endurance by finding that his best efforts terminate in failure. Sometimes it is the obscurity of the disease which baffles him. Sometimes he has, with the ardor of a young recruit, been leading an assault upon an incurable disorder. Sometimes a slightly different therapeutic agent of the same class of drugs is the one really needed.

The experienced therapeutist has learned by sad reflection to snatch victory from the very jaws of defeat If retiring daily before an invincible disease, he keeps his face to the foe, replaces each vanquished agent calmly and quickly by another of well-tested virtue, and leaves no rows of half-empty bottles to mark, like unburied corpses, the line of his retreat. He neither, like the lover of newly imported and untried remedies, risks annihilation by rash charges; nor does he, like the therapeutic agnostic, withdraw into the fortified camp of inaction and leave the field to the enemy; but realizing that his duty is to fight wisely, he ever keeps the field, whether advancing cautiously, or retiring with face to the foe and seeking to learn the causes of his defeat. He will never "give up the patient's case, because nothing more can be done." Help comes sometimes from most unexpected sources. The "weather changes," bringing convalescence. Or an attendant or relative suggests some local simple which meets the emergency, and takes its place forever after in the doctor's armamentarium. Or, moved by unseen impulses, the patient, if hysterical, may take pity on the doctor and get well; and if he has retreated wisely and reluctantly before her superior tactics, and gained her respect, she will almost invariably so capitulate at the last moment, and will ever afterwards choose him as her physician.

As the reputation of some of the world's greatest generals has been gained by bravery and wisdom shown in retreating before a superior enemy, so the practice of many a family physician in a community has been founded by his devoted and unfailing attention in an apparently or really hopeless case.

Sometimes a consultation with a practitioner of greater age or more special skill in some particular department of medicine will bring the desired relief; and, indeed, we hold that in obscure cases the physician is in duty bound to call for such reinforcements. Yet in the contest of therapeutics the practitioner usually stands alone. The obstacles which so stubbornly withstand him should be the agencies by which he is led onward toward the calm reflection, the keen discrimination, the unfailing moral courage, the fertility of therapeutic resource and the pervasive hopefulness of the perfect physician.

THE PRESENT STATUS OF THE OPERATION OF LINEAR CRANIECTOMY.

Until recently the future of the child with premature closure of the cranial sutures has been dark indeed, unlighted by even a single ray of hope. Now, however, it is within the power of every surgeon to offer some little chance of relief, by the operation of excision of strips of the cranial bones, in such a way as to leave bands of connective tissue in the regions of the cranial vault where expansion is most needed.

The exact field of usefulness of this operation is still to be determined. With the evidence before us we can neither make sweeping assertions of its usefulness, nor agree with those who utterly condemn it. While some operators report wholly negative results, others assert that the intelligence of their little patients has in some instances most remarkably increased, so that some of them, who had seemed destined to life-long idiocy, have now fair prospects of becoming useful members of society.

There is a modification of the original "linear" craniectomy, known as the "flap method."which deserves attention; being preferred by some surgeons. The operation offers most interesting possibilities to the young surgeon who will make a practical study of it.

THE TEST OF CHARACTER.

In a preceding column we present to our readers the able oration of Dr. Long before the North Carolina Medical Society. We have read it with unflagging interest, and recommend its thoughtful perusal to each subscriber. North Carolina is to be congratulated on the possession of such a physician and orator. We are convinced that even in Maryland the noble ideals of true manhood need to be continually brought before the minds of those who, like physicians, are prone to have their ideals obscured by daily contact with that which is degrading and perverting in humanity. Though unacquainted with thirst-assuaging

scenes, such as are described, our readers will find something strikingly familiar in the little advertising schemes, the alarmist tactics, and perhaps in the back-biting criticisms pictured from the Sunny South. Especially common among us is the overworked beginner who revels in a practice of from two and a half to three thousand dollars a year "actually collected; to say nothing of what he has booked."

Medical Progress.

EVIL INFLUENCES OF HOT VAGINAL INJECTIONS.

In the *N. Y. Jour. Gynæcol. and Obstetrics*, July, 1892, Dr. Jacobus writes: This cause of secondary amenorrhœa should be borne in mind, for no matter how valuable hot water vaginal and rectal injections are in the treatment of pelvic inflammations, etc., their prolonged daily use in patients predisposed by small or atrophic uteri or ovaries to scanty or irregular menstruation is objectionable and likely to lead to future bad results, though the immediate effect be good. This has been the experience of others too, and even a case of paralysis of the lower extremities has been reported, a few years since, in the *Medical Record*, I think, as a result of prolonged hot vaginal injections. Cases like those just referred to might better be treated locally, when intercurrent inflammatory pelvic conditions exist, by a five to ten per cent. solution of boroglyceride or ichthyol in glycerine, with or without tampons, rather than by hot water, which acts the reversely by contracting the blood-vessels and other tissues.

OPERATION FOR WRY-NECK.

The following brief notes are given by Dr. Pearce Gould, of London, in the *Lancet*, for June 18th, 1892:

A lady aged twenty-eight years was brought to me in August, 1885, by the late Dr. Troutbeck, for very troublesome spasm of the left sterno-mastoid muscle. She first experienced trouble in the neck eight years before, soon after the death of a near relative; the jerking of the head had persisted ever since, gradually getting worse. The patient was a tall, thin girl, and delicate looking. There was no history of fits; she had had facial neuralgia, but not severe migraine. The spasm appeared to be entirely limited to the left sterno-mastoid muscle, and was so severe and constant as entirely to preclude the patient from mixing in society, and at night it was some time before she could get to sleep. Dr. Angel Money applied the constant current to the muscle on nine occasions, but with no benefit; indeed, the spasms appeared to be increased in severity. So on September 10th, 1885, with Mr. Hudson's assistance, I exposed the spinal accessory nerve by means of an incision along the anterior border of the upper part of the sternoid-mastoid muscle, intending to stretch it and excise a considerable portion. In stretching it from the central end I felt the nerve gradually give way, and I pulled out a long, slender nerve from the jugular foramen and excised four inches and a half of it. No special symptoms were noticed from the tearing of the nerve roots. The wound healed without complication, and the patient returned home on September 23rd. She called on me on September 8th, 1886. She was then in much better general health, her head was held erect, and was quite steady. She could turn it freely to the left and about half the distance to the right, and she was gaining power in it. The left sterno-mastoid muscle had completely atrophied, and the cervical portion of the left trapezius

muscle was markedly smaller than the right. The patient was able to again mix in society, and was much pleased with the result of the operation. A year later (October, 1887) Dr. Troutbeck saw her, and reported to me that she was "quite well, except for occasional fatigue felt in the neck; no jerks."

The satisfactory result of this operation was, in my opinion, chiefly due to the fact that the spasm was limited to the one muscle—the sterno-mastoid. I have on two subsequent occasions intentionally removed the central end of the spinal accessory nerve in the same way for spastic torticollis. The operation is quite a simple one, the delicate roots of the nerve rupture and a long tapering filament is drawn out from the spinal canal. These two cases were treated last year, and it is too early to pronounce with certainty upon the result of the operation in them.

SOME REASONS FOR DAILY EXERCISE.

1. Any man who does not take time for exercise will probably have to make time to be ill.

2. Body and mind are both gifts, and for the proper use of them our Maker will hold us responsible.

3. Exercise gradually increases the physical powers, and gives more strength to resist sickness.

4. Exercise will do for your body what intellectual training will do for your mind—educate and strengthen it.

5. Plato called a man lame because he exercised the mind while the body was allowed to suffer.

6. A sound body lies at the foundation of all that goes to make life a success. Exercise will help to give it.

7. Exercise will help a young man to lead a chaste life.

8. Varied, light and brisk exercises, next to sleep, will rest the tired brain better than anything else.

9. Metal will rust if not used, and the body will become diseased if not exercised.

10. A man "too busy" to take care of his health is like a workman too busy to sharpen his tools.—*Glasgow Herald.*

A CASE OF VESICULAR VAGINITIS.

Under the heading of Emphysematous Vaginitis a correspondent of the *Lancet*, July 9th, 1892, reports the following case:

Mrs.—, aged twenty-seven, has been under my care for endocervicitis and erosion of the os uteri for nearly three months. On September 2nd she came to me to have the last application of nitrate of silver made to the cervix, and on passing Ferguson's speculum I noticed the vagina was studded with white spots, some of the size of a hempseed, others that of a small pea. The spots were milky white and about a third of an inch apart. A close examination showed them to be vesicles, and in adjusting the speculum some of the vesicles were ruptured and a watery, opaque fluid exuded. The ruptured vesicles left small pits in the mucous membrane. The cervix was quite free from the vesicles, which were most abundant in the upper two-thirds of the vagina, the lower third and the vulva being unaffected. I had never seen such a condition of the vagina before, and I have a large practice in diseases of women. The milk-white spots suggested the oidium albicans, but closer examination clearly showed the spots to be true vesicles. The patient and her husband were surprised when I informed them of the condition of the vagina, which apparently had given rise to no

special symptoms. I applied the nitrate of silver as usual to the cervix and left the vagina alone. Three days after this the husband came to me and said that his wife complained of an irritating watery discharge from the vagina and some burning of the passage and itching of the vulva. I prescribed, without again seeing the patient, some borax and glycerine, directing it to be used in warm water as an injection two or three times a day. I heard nothing more of my patient for about ten days, when her husband came to consult me about himself. He said, "I have got the same complaint which my wife has just had. It came on a few days after I had connection with her, which was the day before she came to you." I had advised him not to have intercourse with his wife until the vagina should have regained its healthy condition. On examining the husband, I found the whole surface of the glans penis excoriated in small spots or patches; there were no vesicles, but the condition of the glans was very suggestive. I must mention that the irritation and soreness of the penis had existed for one week prior to this visit. There was slight redness of the orifice of the urethra, and occasionally some slight burning in passing urine. There was no discharge, either water or pus. I prescribed a lead lotion and in a few days he was quite well. I regret that I did not examine some of the vesicles for the oidium albicans, as their milky whiteness and rapid disappearance after using a lotion of borax and glycerine, convince me that I might have been successful in my search.

HOW TO USE PEROXIDE OF HYDROGEN.

In a recent number of the *American Journal of Dental Science*, Dr. Brophy says:

I saw a case, a day or two ago, where peroxide of hydrogen was injected in such a cavity as we are speaking about. The patient called on one of our practitioners, and he found what he supposed was a chronic abscess where a tooth had been extracted. He filled a rubber syringe with peroxide of hydrogen and carried it up into the socket of a bicuspid tooth, and let the fluid go. The patient told me that he thought he was going to lose his head. I said, "What do you mean?" "I really thought my head would burst." The peroxide of hydrogen entered the antral cavity which was half filled with pus, and you know what the result would be in such a case. The dentist did not observe the precaution of thoroughly irrigating the cavity with carbolized water or even warm water. He should have cleaned out the greater quantity of the pus, and then he could have made use of the peroxide of hydrogen and removed the little remnants on the mucous wall which the carbolized water would not remove. He would then have the cavity in shape to use boracic acid or whatever he wished. I would put boracic acid crystals in there and let them lie so as to get the prolonged action of the antiseptic. The crystals would dissolve slowly and would serve our purposes better than any fluid.

Usually, if we have teeth in these cases, I would make an opening large enough to secure drainage without a tube.

GOING BAREFOOT IN SEARCH OF HEALTH.

If civilization has its compensations, it brings in its train also certain physical evils of which primitive man knew little or nothing, and which science is constantly endeavoring to lessen or ameliorate. The noble savage rarely suffered from the bodily ills which frequently make life a burden to the products of less hardy conditions, and our rude American forefathers, who laid the foundations of national progress and drove the noble savage away from his familiar haunts, were as tough and vigorous as the original denizens of the woods. The secret of their health, their strength and endurance was found in the fact that they lived

close to nature and were constantly repairing physical waste by fresh draughts from that bountiful mother. Realizing this truth, the latter-day scientists find their best remedies in nature's medicine chest, and are constantly trying to produce for their patients the prescriptions that were so potent in earlier times when prepared by the alchemy of air and sunshine.

Such consultations with nature nearly always prove effective, and even when the specialist becomes a man of one idea, this one idea, if it is caught from the distinguished practitioner to whom all medical men must bow, will be found to contain many grains of truth. It is quite easy, of course, to make the truth in a measure ridiculous by attempting to give it a universal application, or by advancing preposterous claims for it, but beneath the extravagance of the theory may often be discovered some fact of practical value. An illustration of this is found in a paper recently contributed to a New York medical journal by a writer who sees in the habit of wearing shoes a source of serious menace to health, and who thinks that the contact of the foot with good old mother earth would do much to restore a degenerate race to its pristine vigor. Why, he asks, are people who wear shoes "so notoriously inferior to savages, or to people living in a semi-barbarous state, or to the lower animals in powers of recuperation under bodily injury?" And he contrasts the children of the rich with those of the poor to the decided physical disadvantage of the former, who are "pale, puny and sickly," while the latter, he asserts, are rosy-cheeked, strong of limb and bright-eyed. This "barefoot" theory is by no means a new one; and that it is often salutary in practice, especially in the case of children in hot weather, admits of no dispute.

Physicians have often recommended it as a preventive of croup and other childish ailments, and it probably has a tendency to harden and strengthen the whole system, as it certainly does the soles of the feet. Whether the benefit is due to electrical conditions in the earth, as the writer intimates, is a question which scientists must determine. But that there is something irresistibly fascinating and attractive to humanity in such contact with the ground is a fact which no one will gainsay. The same instinct that leads animals to the favorite grasses and herbs draws the first tottering steps of the infant toward the most convenient dirt pile in the vicinity, and mud pies exercise an influence upon the childish imagination that not even the bluest blood or the most aristocratic surroundings can counteract. And even children of larger growth feel the same instinctive yearnings occasionally, and would like to pull off their shoes and stockings and go paddling with the boys and girls in some cool brook or rub the soles of their feet in the moist and pleasant earth. This is probably the reason the seashore is at once so popular and beneficial. The enslaving shoe can be discarded at least once a day with the rest of the regulation costume, and people can bask in the arms and smiles of the old Mother Nature without let or hindrance. The bathing, after all, may be only an excuse for getting in the dirt, as they were used to do when they were children. Civilized men and women, as well as savages, being made of the dust of the ground, possess an affinity for it of which no refinement can entirely deprive them. It is the great self-prescribed medicine and consolation of our youth, as it is the soft and soothing couch to which we gladly turn at the close of the journey of life.

If everybody had pretty feet, with no corns or bunions on them, and if it were always summer, it might be practicable to put the "barefoot" theory into practice, but, as it is, the shoe, like charity, conceals a multitude of defects that the owners do not generally desire to make public. Think of the disenchantment

that might come upon a lover brought face to face, or foot to foot, with feminine pedal enormities, hitherto unsuspected by his ardent soul. Any other calamity might still leave him the courage to write an ode to his lady's eyebrow, but if her feet were not what his poetic imagination had pictured, could he possibly survive the shock to his delicate sensibilities? On the whole, going "barefoot" would probably not do for everybody, but for children, as a rule, it would be an excellent thing in warm weather. If the old woman who lived in a shoe, and who had so many children she didn't know what to do, instead of whipping them, had taken them out of the shoes and let them scamper, free of foot gear, across the fields and in the dirt, she would probably have been a happier mother and would have had a healthier and less troublesome set of youngsters.—Baltimore *Sun*.

Recommendations of Therapeutic Agents.

Reply to "Enlarged Prostate a Myth."—I notice in the April number (*Medical World*), page 131, an article by J. C. Campbell, M. D., speaking rather disparagingly of the attention given to the subject of enlarged prostate and exhorting physicians to "pay more attention to "contractions and soreness of the urethra." I do not think there can be too much attention given to that most distressing and often fatal disease of the prostate gland appendages: two fatal cases having come under my observation within a year, reminding me most forcibly of what may eventually be the means of my "taking off." It is true that, whereas I was once "young, but now am old" (nearly 80), yet never have I suffered my urethra to be impaired by the means he would have us believe. I am convinced that this affliction, diseased prostate, is much more prevalent than he would intimate, if I may judge from the inquiries from physicians that my article on the subject (January, 1891) called forth, no less than fifteen having written of their own cases. If the people throughout the country are afflicted in the same proportion, there must be a great many suffering with it. The "urethral contractions and soreness" he advises us to examine are very simple ailments and easily treated compared with a real enlarged prostate, a fact that I think he would duly appreciate if he happened to be a subject of that "*enlarged prostate rut*" he speaks of. Now, Mr. Editor, it may appear egotistic in me to further encroach on your space or patience, in reference to my experience up to January, 1891, but I venture to obtrude still further, though the subject may be hackneyed. In that article I brought saw palmetto into notice, as having helped me more than anything else I had ever tried, and felt very hopeful of its lasting effect, and can now say that its action on the gland has been effective in preventing further enlargement, but it failed to relieve, except temporarily, irritation of the neck of the bladder, and prostatic portion of the urethra; so I had to use the catheter occasionally. Some four months ago my attention was called to a new remedy called "sanmetto," composed of new palmetto and santal. As a drowning man will "grasp at straws," so I grasped at a bottle of the remedy, and have been using it for about three months, with great relief, for I have no use for the catheter now, and the deposit of mucous, instead of being an inch or more thick in a quinine bottle of urine, as formerly, is now nearly nil, and no pain or irritation on urinating. I think the combination of saw palmetto and santal is a happy idea—the former acting on the gland and the latter on the mucous membrane of the bladder and urethra. It may lose its effect, as other things have, but it commends

itself to my judgment, as covering the pathological conditions better than any other remedy I have tried. For the benefit of those who have written me on the subject, I can say it is pleasant to take the dose, a teaspoonful about three times a day.—H. Knapp, M. D., Lathrop, Cal., in July *Medical World.*

Medical Items.

The Barnes Medical College, of St. Louis, Mo., announces for the coming year a new and spacious building in the heart of the city, with ample clinical and laboratory facilities. Hospital and dispensary privileges free. Special terms to sons and brothers of physicians, and to sons of the clergy. Pinckney French, M. D., Secretary, 904 Olive St.

A certificate of incorporation of the Baltimore Hernia Institute was filed last week in the clerk's office of the Superior Court. The incorporators are Charles E. McCandless, William C. Kloman, Henry W. Matthew, W. Burns Trundle and Francis O. Peterson. The capital stock is $10,000, divided into four hundred shares of the par value of $25 each.

The Sixteenth Annual Meeting of the American Dermatological Association will be held at the Pequot House, New London, Conn., September 13th, 14th and 15th, 1892. The officers are: E. B. Bronson, M. D., New York, President; F. J. Shepherd, M. D., Montreal, Vice-President; G. T. Jackson, M. D., New York, Secretary and Treasurer. A full and interesting programme has been furnished us. It is earnestly requested by the management that a short abstract of every paper read be handed to the secretary for publication in the Transactions of the Society.

The Sixth Annual Meeting of the American Orthopedic Association will be held in Room 39, at the New York Academy of Medicine, September 20th, 21st and 22nd, 1892. There will be morning sessions at 9 o'clock and afternoon sessions at 2 o'clock. On Tuesday evening, at 8 o'clock, Dr. Lewis A. Sayre will receive the members and guests of the Association at his house, 285 Fifth Avenue. At 8 o'clock, on Wednesday evening, the annual dinner will be held in the banquet room of the Academy of Medicine. The programme announces the President's address, by Benjamin Lee, M. D., of Philadelphia, and an interesting series of 31 papers. The Secretary and Treasurer is John Ridlon, M. D., 34 Washington Street, Chicago.

The practitioner of medicine in Russia has, in marked contrast to his American brother, very little liberty in the pursuit of his profession, and none at all save as it is doled out by the police. According to George Kennan, than whom no better authority on Russian laws and customs exists, the physician must get permission from the police before he can practice his profession, and then, if he does not wish to respond to night calls, he must have permission to refuse to go: furthermore, if he wishes to prescribe what are known in Russia as "powerfully acting" medicines, he must have special permission or the druggists will not dare fill the prescriptions. Chemists and apothecaries, both in the cities and in the provinces, are furnished by the police with a complete list of names of all physicans who have the right to prescribe "powerfully acting" medicines, such as anaesthetics, narcotics, and poisons. If a doctor's name is not on this list the chemists dare not fill his prescription for any drug that might be used by a 'terrorist' for "the attainment of illegal ends." —*Med. Fortnightly.*

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CONTENTS

ORIGINAL ARTICLES.

A Case of Recovery from Traumatic Tetanus. By A. K. Bond, M. D., Baltimore. . . 903

Expulsion of a Gall-Stone of Immense Size. By P. C. Williams, M. D., Baltimore. . . 906

"The Tribe of Ishmael;" A Study of the Dark Side of Heredity. By "Probus." . . 907

EDITORIAL.

A New Way of Obtaining Medical Reforms. . 911

The Vacation Problem. 912

CORRESPONDENCE.

Medical Examiners Act. 913

Disinfection by Steam. 914

MEDICAL PROGRESS.

Leprosy in Russia.—Hypnotism.—For Typhoid Tympanites.—Ectopic Gestation.—Surgical Treatment of General Paralysis of the Insane.—Mineral Waters for the Gouty.—An Additional Method for Resuscitation in Drowning. Ulcers of the Tongue.—Diuretin.—Symmetrical Inflammation of the Lacrymal Gland. . 915

MEDICAL ITEMS. 923

Original Articles.

A CASE OF RECOVERY FROM TRAUMATIC TETANUS.

BY A. K. BOND, M. D.,

Lecturer on Diseases of Children and Dermatology in the Baltimore Medical College.

The following clinical study is presented to my readers with the hope that it may, by virtue of the element of personal experience which permeates its recital, somewhat intensify the impressions left by perusal of the more generalized descriptions of the text-books. And I am the more encouraged in my venture by the fact that cases of traumatic tetanus are not numerous in this community.

While some practitioners have seen several cases, others, men of large experience, have never met with a single case.

The remedies given in the text-books are numerous and varied. One observer seems to pin his faith with a sort of superstitious confidence to one drug, and another to a different drug. Some experienced practitioners have come to the conclusion that the patients who are to recover will recover with any reasonable sort of treatment, while those who are to die will die in spite of everything.

I believe that such a view is not only paralyzing to proper therapeutic effort, but also untrue: and I present my case as one in which (although it was of the milder sort) definite therapeutic effects were sought and definite beneficial effects were obtained by treatment, without which life might have been lost.

With the alleged curative method by means of injections of tetanic products, I have at present no concern. Experience has shown that it is not well for the family practitioner to forsake ordinary therapeutic methods for the sake of a

"jugulating" agent of recent introduction, whose scope and virtues, if indeed it has potency, are as yet not thoroughly understood.

The patient whose case is under consideration is a young colored man, seventeen years of age, previously strong and active. For some months he had had occasional attacks of headache and constipation: his "poor health" rendering him perhaps more liable to the invasion of tetanus. On the first day of June, 1892, he cut the ends of both index fingers with a tin-cutting machine, in such a manner as to mash the ends of the fingers and cut through the nails about the matrix.

The tin which he was cutting at the time was clean new tin, but the machine had recently been used to cut refuse tin torn from old buildings; so that the infective material may have been left by the refuse tin on the cutting edges. The cuts, which were quite painful, were dressed without medical advice, by the aid of the druggist, with laudanum and arnica on clean cloths, and the patient returned to his work. The wounds healed but slowly and were quite painful; the reparative action being apparently attended by but little granulation, and by the formation of hard and dry leathery cicatrices or coverings.

On June 11th, while at the tin factory, his jaws and neck began to be stiff, so that he could not eat his dinner. On the night of June 13th muscular jerkings were first observed, but the nature of the disease was not suspected.

At my first visit, June 14th, I found the patient lying flat on his back in the bed, with his feet against the foot-board of the bed, with his head firmly and constantly retracted, and his jaws capable of but slight separation. Every few minutes, sometimes from external disturbance, sometimes without visible cause, he was seized with a spasm about the muscles of the belly and trunk, and with rigid body and spine he would make a powerful lunge downwards against the foot-board. He lay rigid and helpless in this position for a few moments, and then his mother would drag his log-like body up again upon the pillows. These "jerks," as the clonic spasms were called, were ushered in sometimes by a feeling as if he could not get his breath, and sometimes by a subjective sense of hot flushing. Any attempt to turn him on his side caused increased frequency of the clonic spasm above described. He was, with difficulty, helped up for urination. The tonic spasm affected, as far as could be seen, only the neck, jaws, spine and lower abdomen (but affected these uninterruptedly until it passed away in convalescence). There was no sardonic grin, except possibly at the height of a clonic spasm. With the purpose of somewhat controlling the clonic spasms, I ordered potassium bromide, twenty grains, with chloral hydrate, fifteen grains, every four hours, hot cloths to the abdomen, and flaxseed poultices to the fingers; believing that the patient might, by his own vital power, throw off the disease, if a reasonable amount of rest and sleep were secured, and if reflex irritation or repeated infections were prevented by the promotion of healthy action in the wounds.

On the second day of my attendance, as the clonic spasms seemed more painful than before, I ordered one-sixth grain morphia to be given every four hours during the night, in place of the chloral and bromide, and alternating with it during the day. The wounds were also soaked in a strong solution of bichloride of mercury and poulticed as before.

By this treatment the edge was taken off the clonic spasms, although they still recurred, and sufficient sleep was secured. The bowels, whether on account of the morphia or from some tonic spasm of the small intestine walls, were obstinately resistant to large and repeated doses of castor oil, senna and Epsom salts,

but responded satisfactorily throughout the illness to enemeta of water. The urine was normally discharged throughout. The patient's intellect was clear, and continued so. His appetite was good for liquids, which he sucked through a large rubber tube. There was no fever deserving treatment. In spite of the heat of the weather he showed no signs of great physical prostration.

By June 25th the morphia, chloral and bromide began to lose their influence upon the patient, who suffered from frequent clonic spasms during the day and lost much sleep at night from sudden and more severe "jerkings," which caused him often to cry aloud with epigastric pain. His jaws became more closely clenched, and he could not chew food on account of the stiffness and the frequent spasms which were excited by any attempt to separate the jaws. In these spasms, the tongue was very often caught and severely bitten. For the sore tongue he was made to sip a solution of permanganate of potassium and eject it again. In place of the morphia, chloral and bromide, I ordered the fluid extract of cannabis indica, beginning with two drops every four hours, day and night. This was very satisfactory, lessening the intensity and frequency of the clonic spasms and securing sleep. The dose was gradually increased until six drops were taken every four hours, day and night. This dose was given for a week or more and its influence was wholly agreeable and beneficial.

In my record of June 30, two weeks after my first visit, it is stated that he could now move his head a little from side to side, but could not bend it forward. He lay on his back and fanned himself, but any attempt to turn the body on one side brought on clonic spasms. The clonic spasms had shifted at various times, being during the first week more into the epigastrium and legs, then in the right inguinal region, then in the legs alone; and at the date of record, they occurred every few minutes, chiefly in the swallowing apparatus, hypogastrium, and right knee, but were by no means so severe as at the first. For some time the recti muscles of the anterior abdominal wall were rigid as a board, the rigidity being increased during the clonic spasm. At one period each clonic spasm caused a slight evacuation of the bowels.

I do not believe that the diaphragm or muscles of thoracic respiration were at any time affected. The clonic spasms throughout the case lasted but a few seconds. The respiration was natural, except as affected by the clonic spasms of the abdominal recti. The pulse was throughout slightly accelerated, but otherwise natural. There was no noteworthy elevation of temperature. The disinfection of the cut fingers, and subsequent constant application of poultices, seemed to have no influence on the tetanic condition. They pained a little until near the end of the illness, and the nail of one finger came off during convalescence.

In addition to the administration of the cannabis indica, the body was repeatedly sponged, to cool it, with warm vinegar and water; poultices of flaxseed and hops, and turpentine stupes were applied to the epigastrium, and a little wine was given.

Loud noises, irritation by flies, attempts to speak forcibly or to open the mouth wide, all caused clonic spasms during the first three weeks. Although the jaws could not well be opened by the patient, I could easily open them by pressing on the lower teeth, although this pressure caused clonic spasms. The tongue, thus seen, was white-coated and very sore from being bitten.

By June 30th the patient was evidently on the road to recovery. His spirits were good; the face looked bright; and the spasms were quite bearable. The disagreeable lungings downward against the foot-board of the bed had ceased after the first three or four days of my attendance.

On July 5th (twenty-four days after the onset of the lock-jaw) I found him lying very quiet, free from jerking. He had had only three clonic spasms during the preceding night, but bit his tongue each time; the clonic spasm coming on during sleep and the bitten tongue waking him. The neck was not so stiff, but quite painful. He could open his front teeth one-fourth of an inch. The muscles of the side of the neck, which had been hard-knotted two days before, were now soft; the muscles of the nape were still hard. The knee-pain and all other pain except about the neck had ceased. The bowels were easily regulated; the appetite was good, abdominal respiration was free; the pulse was normal. He slept soundly at night and bore six drops of the cannabis indica well.

On July 8th he was able to part his teeth three-fourths of an inch, and ate half a dozen meals of soft food a day. He had no clonic spasms in the day time, but bit his tongue badly at night, until his mother hit upon the plan of letting him sleep with a spoon-handle laid across between his teeth. Every now and then while he slept she would hear the spoon-handle rattle as his jaws closed spasmodically on it, but the tongue was not bitten; there was now no pain. He could turn his head from side to side, but not forward. He had an occasional cramp in the leg. He sat up a little on this day. The finger of the left hand at times still pained a little. The nail was not yet off. All medicine was omitted during the day, the cannabis indica being given in same dose every four hours at night.

On July 13th (thirty-two days after the onset of the lock-jaw) the cannabis indica was stopped, and a tonic of the elixir of iron, quinia and strychnia phosphate was given. On July 20th he was discharged from medical care, though still somewhat weak.

The case demonstrates clearly the ability of the human body to free itself in time from the poison of tetanus if the infection is of moderate intensity. In the use of therapeutic agents I endeavored simply to aid the body in its contest with the disease, by regular evacuation of the bowels, by the moderation of excessive and fatiguing spasm, by the securing of sufficient restful sleep, and by the administration of abundance of simple food, such as milk and beef-tea. I did not push the drugs to their extreme therapeutic limits, because under the doses above given the clonic spasms were reduced within harmless limits. The bodily powers of the patient showed no sign of failing. The tonic spasm did no harm, being simply uncomfortable. Serious spasm of the respiratory muscles—which frequently brings death in fatal cases—was at no time imminent; and I judged that, even if the shifting clonic spasms should attack the respiratory apparatus, their duration was so brief that each spasm would pass off many seconds before suffocation could set in. The tonic spasm showed no sign of shifting from the muscles of the jaws, neck, back and lower abdomen, where it was first located. Whether tetanus would have occurred if the wounds had been under proper surgical care immediately after the accident is of course uncertain.

Cor. McCulloh and Biddle Streets.

EXPULSION OF A GALL-STONE OF IMMENSE SIZE.

BY P. C. WILLIAMS, M. D., BALTIMORE.

Early in March, in this year, I was called to see an old lady, 72 years old, who was suffering from an attack of cholera morbus, which was caused by imprudence in diet. The pain and diarrhœa were soon relieved, but the vomiting was very obstinate. After a few days the old lady vomited fæcal matter in great abundance. This led me to suspect intestinal obstruction, and after careful in-

vestigation I discovered in the ileo cæcal region a well-defined oval tumor, apparently about two inches in diameter. I inferred that this tumor was an intussusception of the bowels produced by the prolonged vomiting. On several occasions I had relieved cases of intussusception by the administration of large doses of chloral, and keeping the patients profoundly under its influence for thirty-six to forty eight hours, during which time the constriction of the bowel became relaxed, and the intussusception relieved. Recalling these cases, I gave larger doses of chloral and morphia. The doses were promptly vomited. I then gave an enema of thirty grains of chloral and two drachms of fluid extract of senna every two hours. This produced profound sleep, and at the end of thirty-six hours my patient was relieved by the passage of an immense gall-stone per rectum. The stone was a *smooth cylinder, one inch and five eighths long;* with a diameter *one inch and one-eighth*, and a circumference of *three inches and five-eighths*. Both ends of the cylinder were smooth and spherical. After the passage of this stone the old lady rapidly recovered her health, and is now better than she has been for several years. This case and its fortunate termination was of great interest to me.

Upon inquiry I ascertained that last July (1891), this old lady had a severe illness at Atlantic City, which was thought to be a peritonitis. From this attack she recovered slowly, but continued very delicate until she came under my care for the first time, last December, 1891, with an attack of "grippe." She rallied from the "grippe," and in March came under my care as described above.

I have no doubt that during the illness at Atlantic City the gall-stone ulcerated through the gall-bladder into the intestines and gradually passed down, with no special symptoms, until it reached the ileo-cæcal valve, where it was arrested and caused the fæcal vomiting that disclosed the true nature of her sickness.

The two points of interest in this case were: First, the great size of the stone, which was the largest I have ever seen. Second, its prompt expulsion through the valve under the prolonged use of chloral and senna in large doses.

900 Madison Avenue.

"THE TRIBE OF ISHMAEL:" A STUDY OF THE DARK SIDE OF HEREDITY.

BY "PROBUS."

The late Reverend Oscar C. McCulloch, of Indianapolis, was one of the choice ones of earth, whose every breath was drawn that he might do some good deed for degraded and suffering humanity. He made the greatest contribution to the literature of charity when he discovered "The Tribe of Ishmael" and handed its records down to posterity. It was not the first research of its kind, but it is without doubt the best, fullest and most absorbingly interesting that has yet appeared.

Briefly abstracted from his own narration, the salient points of his investigation are the following:

John Ishmael married a half-breed woman and came to Indianapolis about 1840. Three sons of this marriage married three sisters from a pauper family named Smith. Of these marriages thirteen children raised families, having sixty children, of whom thirty are now living in the fifth generation. Since 1840, this family has had a pauper record. They have been in the Almshouse, in the House of Refuge, the Woman's Reformatory, the penitentiaries, and have received

continuous aid from the township. In their history are murders, and a large number of illegitimacies. They live by petty stealing, begging, and ash and swill gathering. In summer they "gypsy" or travel east to Ohio or west to Illinois. In the fall they return. They are not intemperate to excess. Their condition is met with almost unlimited public and private aid, thus encouraging them in their idle, wandering life, and the propagation of similarly disposed children.

Another typical case is the Owens family, which came, as did the Ishmaels, from Kentucky. William Owens had three children who raised pauper families. One son of the third generation died in the penitentiary; his two sons in the fourth generation have been in the penitentiary; a daughter in the fourth generation was a prostitute, with two illegitimate children; another son of the third generation had a penitentiary record and died of delirium tremens. There have been several murders and a continuous pauper and criminal record. This line has in it an illegitimate half-breed Canadian woman. There is much prostitution and but little intemperance.

Brook Owens had a son John who passed as a Presbyterian minister. He raised a family of fourteen illegitimate children. Ten of these came to Indiana, and their pauper record begins about 1850. Of these ten, three raised illegitimate families in the fourth generation, and of these, two daughters and a son have illegitimate children in the fifth generation.

Thirty families were thus traced. These came mostly from Kentucky, Tennessee and North Carolina. The earliest generation contained sixty-two individuals, but the facts were obtained of only three. In the second generation the history of 84 persons was discovered; in the third, 283; in the fourth, 1840 to 1860, 644; in the fifth, 1860 to 1880, 679; in the sixth, 1880 to 1890, 57. This makes a total of 1,750 individuals. This history has the Clem case among its murders. It includes prostitution, unlimited petty thieving and larceny, and nearly every crime of any note in Indianapolis. Leaving out surgical cases and acute general diseases and cases from other counties, this history embraces 75 per cent. of the cases in the City Hospital. In twenty years township trustees have paid $5,000 in passing these people from place to another, each officer trying to shoulder them upon the next. A complete investigation of the purely pauper element from time to time applying for relief at Indianapolis would have embraced 250 families and over 5,000 individuals, all showing the hereditary characteristics of pauperism. The lines of relationship are so intertwined that if one be picked up the whole 5,000 will be drawn.

The discoverer of these facts, Mr. McCulloch, was a capable leader in the battle against pauperism. He secured the establishment of the "Friendly Inn," where wood-sawing and other work was required, so that no able bodied person should be fed without making some compensation. He secured the establishment of a county workhouse, so that the jail might cease to be a refuge for idlers. The Flower Mission Training School for Nurses was organized and sends out district nurses. Free baths were established. He drew the law by which the Board of State Charities was formed, and given ample supervisory powers over the benevolent, penal and reformatory institutions of the State. He founded a dime savings and loan association, a children's aid society, and a summer park and home for sick children.

He was able to secure legislation for the organization of charitable work for his city and State. He became the president of the National Association of Charities and Corrections. He died last December, not yet forty-nine years of age.

The above facts have been taken from the May issue of the *State Charities' Record*, New York, from a paper by Lucius B. Swift. The *Charities' Review* for

January contains a biographical sketch, with an admirable photogravure of Mr. McCulloch, which shows that this admirable character was an evolution from behind the counter of a drug store in Fremont, Ohio. If the Tribe of Ishmael is a type of social degradation, as its discoverer termed it, may we not say that the life of the latter is a story of social renovation of priceless value to all Americans? Just as those demoralized "American gypsies" were swift to run into the ways of vice, prostitution and disease, going on from bad to worse along the dark side of heredity, just so we see this lowly-born philanthropist rising higher and higher into the light, a blessing to hundreds who may never hear his name. This may be said to be the bright side of heredity.

THE INFUENCE OF ETHER ON THE RESPIRATION OF WOMEN.

In a contribution to the *British Medical Journal*, July 16, Dr. Ferguson, of Edinburgh, says:

I have frequently observed, both while giving ether myself and seeing it given to women who were undergoing abdominal section, that after complete anæsthesia was established, the type of breathing changed from thoracic to an exaggerated diaphragmatic type. I have seen this repeatedly, and called the attention of others to it. In many cases the undue abdominal movement thus produced has been a source of considerable annoyance to the operators on account of the consequent difficulty in making the abdominal incision. I have never observed such a state of matters in chloroform anæsthesia.

I thought at first that ether must produce a very powerfully stimulating effect upon the origins of the phrenic nerves in the upper part of the spinal cord, causing the diaphragm to act so vigorously that the action of the spinal nerves upon the intercostal muscles would be, so to speak, a work of supererogation, thus accounting for the complete, or almost complete, cessation of the thoracic breathing for the time.

That explanation, however, is untenable, and cannot be accepted in the face of physiological experiments. It seems most likely that the action of the ether is to paralyze temporarily the nerves concerned in the mechanism of thoracic breathing, which is thus put in abeyance. The medulla, as is well known, is the last part of the nervous system to be influenced by ether, and it would also seem that the upper part of the cord, along with the phrenic nerves, are likewise unaffected in ordinary anæsthesia from ether. This would account for the phenomena observed, as the impulse from the respiratory centre would pass down the phrenic nerves, while the various medullary centres would be still further stimulated to increased action by the imperfectly aërated condition of the blood, which is usually present when ether is given.

THE MECHANICAL RESULTS OF UTERINE VERSIONS.

Discussing this subject in the *Lancet*, July 16th, Dr. Oliver says:

In the animal and vegetable kingdoms we have abundant proof that mere shape does not interfere with the passage of that fluid which nourishes the tissues. The tendrils and branches of plants perform many gyrations and assume a variety of shapes without the vascular system in any part of its course being necessarily disturbed. Again, the influence of pressure and friction is undoubtedly exaggerated, for every day we find new growths developing in the pelvis, arising, it may be, from the uterus or ovaries and attaining a great size, yet the pressure made by these produces little or no discomfort unless they become confined, when the increased tension necessarily produces pressure symptoms.

It is alleged, too, that flexions and versions are a cause of sterility, as they create a barrier to the entrance of the seminal fluid. If we examine the genital organs of the females of many of the lower animals we shall observe that greater barriers to the entrance of seminal fluid exist naturally in many of them. The spermatozoa appear to experience no difficulty whatever in effecting an entrance into the corkscrew-shaped uterus of the dugong. In the cervix and body of the uterus of the sheep and goat we find groups of laminæ presenting the appearance of a number of successive ora tincæ, and many no doubt would be disposed to affirm that these irregularities in the canal would hinder the progression of the spermatozoa.

A careful study of the various methods whereby the process of fecundation is carried on in plants and animals and a close examination of the genital tract in mammalia compel us to admit that the spermatozoa and ova are attracted towards each other and that they do not meet and coalesce simply because they happen to be traversing the same passage. It sometimes happens that this elective affinity is absent and fecundation is then impossible. In the case of fishes, for example, it is this elective affinity—this attraction between the ova and spermatozoa—which keeps the species pure; without this influence hybrids would abound. In the case of the ornithorhynchus we find a cervix uteri located on each side of the roof of the uro-genital canal. Each cervix presents two orifices; one—the lower—communicates with the ureter, whilst the other—the upper—leads to the body of the uterus. If, therefore, the process of fertilization depended simply upon chance we would be justified in asserting because of the structural arrangement that the female ornithorhynchus would seldom become pregnant, for the spermatozoa would tend to enter the first opening which leads to the ureter, and would thus fail in their mission. It is evident, however, that the spermatozoa seldom, if ever, enter this opening, but are attracted to that opening which leads to the uterus and ovary. In the macropus major—a marsupial animal—we find also a structural arrangemnt of such a character that if the meeting of the spermatozoa and ova depended purely upon chance the species would run fair prospects of being speedily extinguished. Often being the results, as sometimes the causes of uterine and peri-uterine diseases, their treatment should be combined with efforts at the alleviation of these states. There can be no doubt that the displacements of the uterus are the result of intrinsic or extrinsic changes, but I am fully convinced that if greater caution were exercised in treating these mal-positions and altered configurations of the uterus, many women would be freed from a great deal of suffering, and many who have become invalided in consequence of a too vigorous treatment would pass through life more comfortably.

The Board of Managers of the State Insane Asylum at Fulton, Mo., deserves great credit for departing from an old and time-honored custom in the selection of a superintendent. Up to the time of Dr. Atwood's appointment, the qualifications of a candidate for the superintendency of a Missouri asylum were that he must have a good political pull and be without experience in asylum work. Experience, instead of being deemed necessary, was rather disqualifying than otherwise, and the fact that a man had served on the staff of an asylum debarred him from being a superintendent. So far as it is possible to ascertain, the recent election of Dr. Wilson, lately an assistant physician, to the superintendency of the Fulton Asylum, is the first instance in the history of Missouri in which an assistant physician has been elected superintendent, and the second time a physician of previous asylum experience has been likewise honored.—*Med. Fortnightly.*

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A. K. BOND, M. D., Editor.

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BALTIMORE, AUGUST 13, 1892.

Editorial.

A NEW WAY OF OBTAINING MEDICAL REFORMS.

We read with interest in the *Lancet*, of July 9th, that certain English physicians have hit upon a new method of influencing legislation in favor of needed reforms. It seems that in Bradford a deputation of medical men waited upon one of the candidates for Parliament and inquired, *in advance of election*, what his sentiments were touching certain matters of interest in public medicine. Among the important subjects brought to his attention was this: "The progress of unreasonable legislation which singled out the medical profession for the compulsory performance of certain duties which the Legislature had come to regard as of great public utility. Now, the medical profession objected strongly to the knowledge which they had gained without the assistance of the Government in their medical studies being claimed by the public as their property under any circumstances and whether they were paid for it or not. At the present time a medical man was under legal compulsion to sign a certificate of death, for which he received no remuneration whatever. By law the certificate could only be utilized for the purpose of burial, but in practice it was utilized for insurance, for club purposes and many others. The notification of infectious diseases had also been made compulsory on medical men, a thing which was without analogy in other cases."

The candidate expressed his astonishment at the number of facts brought to his knowledge for the first time. They were such as called for the serious consideration of the Legislature, and he promised, if returned to Parliament, that any bill bearing upon the medical profession or its relation to the public, either directly or indirectly, should not be carried without receiving his most serious attention, and he would, as far as in him lay, urge this upon those members of the House with whom he had any personal influence.

The deputation thanked him for the interest he took in the matter and the courtesy with which he had received them, and then retired.

Commenting editorially upon this, the *Lancet* remarks: "It is certainly a somewhat unique occurrence for a body of medical men to interview a candidate for parliamentary election, with a view to ascertaining whether he is sound on important topics in which they are interested. 'Tempora mutantur, et nos mutamur in illis.' In these days, when every profession and separate interest has come to press forward its claims on the attention of Parliament, those who are too backward and modest to do so are apt to be forgotten and neglected. It may be owing to this, to some extent, that the medical profession has never received that honorable recognition and distinction from Parliament to which it is so justly entitled from the eminent services it incessantly renders the nation and from the learning and ability of its members. Hence we cannot but highly commend the action of the medical practitioners of Bradford who waited on one of the candidates for Parliament and laid before him some important questions on which they wished to know his opinion before the polling-day. The action of the deputation was all the more praiseworthy, seeing that, following the high traditions of our profession, they sought rather to gain benefits for the public than merely to forward their own particular interests. It is true they uttered a protest against legislation which has recently singled them out from the rest of the population and placed them under penal obligation to render services to the public for which in some instances they receive no remuneration. Medical practitioners are not State officials. If the State wishes to reap the fruits of medical science it must requite the services rendered. The most obvious way of doing this would be by assisting the profession in the acquisition of that knowledge which the State is now coming to see is indispensable to the well-being of the public and by protecting medical men in the practice of their profession."

We quote this opinion of the journal which is the acknowledged representative of British medical thought with all the more interest, because it is, as far as we know, the almost universal opinion of American physicians, *outside the circle of health officials*. We believe that it is well grounded, in spite of repeated decisions of courts of law to the contrary. American physicians might, without loss of dignity, follow the example of their British neighbors, and, in closely contested elections, call upon candidates for the State Legislature in regard to such reforms in medical legislation.

THE VACATION PROBLEM.

"To skip, or not to skip;" that is the problem. Whether 'tis better in the town to suffer the heat and swelter of the month of August, or to take a gripsack in the hand and migrate to mountain climes where blows the cooling breeze, where nestling lakes and roaring, leaping torrents, where peaks, high-towering toward the azure sky, persuade to daily tramps and nightly slumbers; or to the

seashore, where the roar of surges, breaking in foam upon the sloping beach, dotted with children building sandy castles, invites to gambols in the rolling waves. To fish, to sail, to strive in tennis matches, or trip the light fantastic toe in mazy dance; to drive, when the tide is out, along the sea-beach, and watch the moon set in the troubled sea. These are the visions that flit through our brain-cells, the centres that preside o'er thoughts of fantasy.

But from those brain-cells which are taught by science there come forth images that give us pause—the clustered rods of the typhoid bacillus, lurking in myriads in the hotel well, borne in the seepage from the neighboring cess-pool; the organisms which thrive in dysentery, each form perhaps more toxic than the other, and with them mixed the germs of common sepsis, to sap the strength of an unwary host. Coiled on the mountain sleeps the deadly rattler, with lethal dose for hypodermic use, and at the seaside in the bathing garments, hired to the guest for temporary wear, there hide the active germs of grave infections—of eczema, chancroid and syphilis—ready to fasten on the fretted skin.

These apparitions of uncertain evil puzzle our wills, and make us rather bear the city trials so familiar to us, than fly to others which mayhap are worse. Thus science doth make cowards of us all; and expeditions which in youth we longed for are put away without a thought of sadness. We go about the daily round of duties, perspire enough to keep our bodies cool, and take the dusty streets and muddy water with which the city fathers furnish us as things to which we are now quite accustomed, to which through long exposure we are made immune.

Correspondence.

MEDICAL EXAMINERS ACT.

Editor Maryland Medical Journal.

Your publication of Dr. Scott's letter, and your reply thereto, in your issue of July 30th, direct public attention most forcibly to the recent "Medical Examiners Act," which it occurs to me should not be judged too severely or construed after too strict a technical construction by our leading State medical journal, but it is entitled at the hands of every well-wisher of the profession and the public, on account of its importance, its far-reaching usefulness, to full and equal justice, and it should therefore be faithfully upheld. I am acquainted with few laws that are not apparently susceptible at some point of at least two constructions, and this one perhaps will not prove an exception. It strikes me, however, that while the language of section 39 of the Act might *seem* to refer to those only who have not practised medicine or surgery before, the evident intention of the law is made plainly manifest that it refers to *all who have not* practised in *this State before*, or rather were not practising when the law went into effect, if you will consider that it is a law relating exclusively to this State, and by the unmistakable language of section 49, wherein it so clearly says to whom it does *not* apply, viz.: commissioned surgeons of the Army, Navy or Marine Service, and *to physicians or surgeons in actual consultation from other States.*

If it has no bearing on practitioners from other States, why, then, should it so

particularly recite, in words void of ambiguity, in what capacity only shall those from other States practise here at all, without first obeying the mandates of said law?

The construction of the law puts all on an equality, both residents and non-residents, who begin to practise in this State after the law went into operation. One may have been a resident for many years, but not a practitioner now (*i. e.*, at the time the law became operative); having discontinued same before, he could not therefore renew or begin his practice without first complying with the law.

This law under our construction of it does not discriminate against our own citizens in favor of those residing elsewhere, but it says wherever he may reside at the time the law begins to operate, if he at that time was practising medicine, etc., in this State, is not required to possess the qualifications of said Act. If he was not practising in this State, however, *wherever* he may reside at the time the law goes into operation, he must possess said qualifications, unless he is of the class not embraced in its provisions and exempt under section 49 of said Act, which section to my mind clears away any and all doubt that may have before obscured the full intention of the Act.

Centreville, August 1, 1892. JAMES BORDLEY.

DISINFECTION BY STEAM.

Editor Maryland Medical Journal:

I herewith enclose a communication from Dr. A. N. Bell, the well-known editor of the *Sanitarian*, touching my article on "Disinfection by Steam" (JOURNAL, June 4, 1892).

PROF. E. F. CORDELL, M. D.

I have for many years read everything I have come across on steam disinfection. A few days ago I first saw your contribution on the subject. I am surprised to read in your paper that we owe the discovery of the germicidal powers of steam to Dr. Koch himself. Will you kindly inform me when Koch made the discovery. I, myself, used steam effectually in the disinfection of a ship of yellow fever, first in 1848. I have frequently used it and caused others to use it on infected vessels, merchandise, clothing, etc., since, for that and other infections. For a period of more than thirty years I have repeatedly described, written and published (Trans. Quarantine Convention, Boston, 1860; New York State Medical Society; a public health association; a medical association; *Sanitarian*, and other publications; and at the Ninth International Medical Congress, Washington, 1887), summarized my observations up to that time under "The History, Practical Application and Efficiency of Steam as a Disinfectant." And I have added some to it since. With this record, and a memory which includes a good deal more, I am led to ask the question as to *date* of Koch's discovery. You may take it for granted that I well know that Koch, and some older bacteriologists than he, disputed the germicidal power of steam, however efficient it had been proven to be against infectious diseases attributed by all scientific men to germs, until disease germs were discovered and experimented upon; and that, following the lead of Tyndall, because *some* germs found in certain hot springs were found capable of resisting a temperature of 300° F. or more, they applied that knowledge to *all* germs. It was faith in such knowledge—opposed to that which I had for more than thirty years demonstrated to be practical—that the secretary of the treasury, half a dozen years ago (absence from my library and record will excuse my not naming the exact date) promulgated the necessity of applying a dry heat at 350°F.

(enough to destroy many articles of merchandise) to all infected material before fratique! And this was accepted by the convention of the State Health Officers at Washington, about six years ago. But shortly thereafter Sternberg announced, if he did not discover, the germicidal effect of steam on disease-germs (I think before Koch) at even less than 145° F., which effect *I had published* in the *Trans. Med. Soc. State of New York*, twenty-five years before. I have directed a copy of the *Sanitarian* for August to be sent to you, containing some editorial matter on the subject, which was in type before I read your paper."

A. N. Bell, M. D.

To this letter from Dr. Bell, I reply that I cannot at present give the date of Dr. Koch's researches, although to one in the city they are readily accessible; also that the crucial test of the germicidal power of steam must be made in a pathological laboratory by a practical bacteriologist. I wrote some time ago to Dr. John S. Billings and Dr. Abbott to learn whether there were any portable disinfectors (for the use of steam under pressure) made in this country, and neither of them knew of any such apparatus.

Dr. Billings says: "I think there would be no difficulty in having such an apparatus constructed of any size that might be deemed desirable by any of the firms engaged in the steam-heating business. Dr. Adams, of Pittsfield, Mass., has been making inquiries with regard to portable ovens to be operated by steam; but one month ago (*i. e.*, about April 1st) he did not know of any that were manufactured in this country. I have called the attention of several steam-heating engineers to the desirability of designing patterns of such apparatus."

Dr. Balls: "I have no doubt that for a public disinfection station for all articles that can be properly submitted to steam, about 240° F., under just sufficient pressure to prevent the deposition of moisture upon the articles, is the most certain and reliable means of destroying infection in such articles.

Dr. Abbott writes: "As to the large municipal disinfecting stations, they involve so much detail in construction that it is hardly possible to give an idea of such an apparatus in a letter. It would involve drawings and measurements that would have to be especially prepared. There exist a number of forms of portable disinfection apparatus in Germany and France. . . . It is possible to design an apparatus that will give absolutely perfect results at no great expense."

Professor Welch has called my attention to a portable apparatus manufactured in different sizes by W. Budenberg, Dortmund, Germany, and adapted for use by cities, communities, hospitals, etc. The price of the apparatus, including stove, packing, etc., varies from 185 to 385 marks ($46 to $96) in Germany.

Orkney Springs, Va. Eugene F. Cordell, M. D.

Medical Progress.

LEPROSY IN RUSSIA.

Miss Marsden, who has recently been travelling in Siberia with some official assistance, to investigate the extent of leprosy in Siberian Russia, makes a report of which the following is the substance:—Leprosy exists as a disease in a district extending over several thousand versts. No provision whatever is made for the care of the sufferers. As soon as the disease declares itself the victim is driven into the forests, and never allowed to come again into contact with his fellow creatures.

A number of wretched "yourtes" (huts) have been half built, half excavated from the ground, and in these shelters the lepers must live without any clothing except a few miserable old sheep skins, all through the rigors of a Siberian winter and the tropical heat of the summer. These "yourtes" are always in the most distant parts of the forests, and are hundreds of versts apart, so that anything like superintendence on the part of the authorities is out of the question. The main food of the lepers is the bark of trees, and small quantities of rotten fish which their relatives from time to time deposit for them at a short distance from the huts. Many were blind, and some insane. They were of all ages and in all stages of disease. Some of them have lived in this state for twenty years. With regard to the plant which was the chief object of her journey, Miss Marsden could obtain but little information. It exists, and Miss Marsden was able to bring back a considerable quantity of it with her for examination. With reference to its alleged virtues in the cure of leprosy, however, no trustworthy evidence could be obtained. It is Miss Marsden's intention to return to Yakutsk, and to establish a leprosy colony at Valuisk, on the river Velui. A committee has been formed at Yakutsk for this purpose, consisting of the Governor of Yakutsk, two priests, and several of the leading officials and inhabitants. The idea is to erect a village consisting of ten small cottages, a hospital, a church, a school and a workshop. Each leper on admission will spend some time under treatment in the hospital, and after he has improved somewhat in general health he will be transferred to one of the cottages, and provided with such employment as he may seem fit for. On Miss Marsden's return to Moscow her report excited so much interest that a Russian princess in one of the convents there, with five Russian Red Cross sisters, volunteered for service in the leprosy-stricken district. No importance need be attached to the so-called plant remedy, but it is the first time that good work has been done *en route* in aimless searches for a philosopher's stone.—*British Medical Journal.*

HYPNOTISM.

The following from the *British Medical Journal*, July 23, is the report of the committee appointed by the Association to consider the value of hypnotism as a therapeutic agent: The committee having completed such investigation of hypnoptism as time has permitted, have to report that they have satisfied themselves of the genuineness of the hypnotic state. No phenomena which have come under their observation, however, lend support to the theory of "animal magnetism."

Test experiments which have been carried out by members of the committee have shown that this condition is attended by mental and physical phenomena, and that these differ widely in different cases.

Among the mental phenomena are altered consciousness, temporary limitation of will power, increased receptivity of suggestion from without, sometimes to the extent of producing passing delusions, illusions, and hallucinations, an exalted condition of the attention, and post-hypnotic suggestions.

Among the phenomena are vascular changes (such as flushing of the face and altered pulse rate), deepening of the respirations, increased frequency of deglutition, slight muscular tremors, inability to control suggested movements, altered muscular sense, anæsthesia, modified power of muscular contraction, catalepsy, rigidity, often intense. It must, however, be understood that all these mental and physical phenomena are rarely present in any one case. The committee take this opportunity of pointing out that the term hypnotism is somewhat misleading, inasmuch as sleep, as ordinarily understood, is not necessarily present.

The committee are of the opinion that as a therapeutic agent hypnotism is frequently effective in relieving pain, procuring sleep, and alleviating many functional ailments. As to its permanent efficacy in the treatment of drunkenness, the evidence before the committee is encouraging, but not conclusive.

Dangers in the use of hypnotism may arise from want of knowledge, carelessness, or intentional abuse, or from the too continuous repetition of suggestions in unsuitable cases.

The committee are of the opinion that when used for therapeutic purposes its employment should be confined to qualified medical men, and that under no circumstances should female patients be hypnotized except in the presence of a relative or a person of their own sex.

In conclusion, the committee desire to express their strong disapprobation of public exhibitions of hypnotic phenomena, and hope that some legal restriction will be placed upon them.

FOR TYPHOID TYMPANITES.

In a brief contribution to the *University Medical Magazine*, July, 1892, Dr. Nealey, of Bangor, Maine, says:

I have always considered tympanites as a dangerous element in typhoid fever; for I have seen several patients die apparently from the distention due to the accumulated gases, a condition which I was unable to relieve satisfactorily. The bowels often fill with alarming rapidity, this being probably the cause of perforation in many cases.

I saw a case in consultation last year, which was undoubtedly intelligently treated. The distention was in the extreme. So far as I was able to determine the case was uncomplicated with perforation, and it seemed as though the man would live if relieved of the accumulation of gas. All of the usual methods had been applied—injections, aspirations and rectal intubation—but with negative results.

A similar case occurred in my own practice during the last year. A boy 9 years of age, during the third week of the fever, suddenly developed an alarming tympanites. The abdomen was fearfully distended, the lower part of the chest wall was widely forced out, stomach collapsed and unable to retain drugs, food or stimulants. Respiration was labored and rapid. This was a case that I had been holding up under heroic doses of stimulants, and without them he began to sink rapidly. I considered the end certain and close unless relieved of this condition. I tried all of the usual methods without giving the needed relief. I then used the injection which I commonly use in abdominal section; one ounce of salts, two ounces of glycerine, three ounces of warm water and thirty drops of turpentine. In thirty minutes the child began passing liquid stools, accompanied with an immense quantity of gas, with very decided relief of alarming symptoms. The injection was repeated in a few hours for another rapid accumulation of gas, with the same results. The child made a perfect recovery, although it was one of the worst cases that I have ever seen. I have repeatedly used this injection since in milder cases for constipation and accumulation of faeces and gas, and it has seemed to be all that one could desire in its effects.

ECTOPIC GESTATION.

After mentioning the usual signs of this condition as obtained by vaginal examination, Dr. Ross (*Buffalo Med. and Surg. Jour.*, August, 1892) says:

I would like to give the reasons for the foregoing symptoms so that they may be more readily brought forward on the spur of the moment at the sick-bed.

The very cause of the sterility is the cause of the fertilization of the ovum and its non-removal from the tube. For many years the egg has managed to escape fertilization, but, at last, one of the spermatozoa, more vigorous perhaps than his fellows, has reached the egg and the damage is done. Many of these patients contract gonorrhœa soon after marriage; the tubes are affected, but only to a minor degree; the ciliated epithelium is shed, and the tube is functionally imperfect. The supposed miscarriage always requires rigid scrutiny. Close cross-examination will generally elicit the fact that the doctor said it was a false pregnancy, or that he thought it was a miscarriage, although unable to find a fœtus. The discharge of blood is due to the separation of the decidua. This forms exactly as it does when a genuine pregnancy occurs. This bleeding from a uterus that is next door neighbor to a pus tube or ovarian cyst is nothing unusual. It frequently occurs after abdominal operations, and may even occur into the vagina from the stump of the cervix left after hysterectomy. This symptom cannot, therefore, be relied upon. It is frequently entirely absent. As to pain, the dysuria, dyspareunia, dyschezia, are the accompaniments of so many other intrapelvic conditions that they cannot be relied on in this connection. Pain may indicate rupture of the tube and hæmorrhage, or such hæmorrhage may occur with scarcely noticeable pain. The presence of the apparent foreign body will of itself produce pain that is likely to attract the patient's attention, but is not severe. This pain is of very great importance. The woman has been practically a well woman until it set in. What diseases produce such pain in a healthy woman? There is no evidence of history of recent gonorrhœa, though there may be of old infection. The woman has had no miscarriage, she has had no intermittent attacks of pelvic inflammation, but while progressing well, though barren, she suddenly, in the midst of health, becomes an ill woman. Ectopic gestation is the only disease that will produce this condition. It is often put down to sweeping the house, doing a day's washing, straining at stool, and a hundred and one other causes physiologically and pathologically unexplained, but will be found by the abdominal surgeon to be due to the presence of an ectopic gestation. I am now speaking from actual experience. In whist, we say "play trumps" when in doubt; well, when dealing with pelvic diseases, diagnose by exclusion, and when you meet a peculiar puzzling condition that feels neither like a pus tube nor cystic ovary, that is too soft for a fibroid with a pedicle, that is too hard and too movable for a hydrosalpinx, that does not feel in shape like an ovary, but is too hard for a tube, that takes some eccentric position between uterus and bladder and simulates that disease of the ancients, "pelvic cellulitis"—then make a guess—guess ectopic gestation, and from actual experience I know that your guess will probably be correct.

Do not rely on breast symptoms, or sickness at the stomach, or peculiar longings, or a woman's own ideas of her condition, or you will find that you have trusted in vain. In no cases must greater care be observed in eliciting all the facts—the real, not the imaginary facts. Leading questions must be avoided or the symptoms can be made to suit every pelvic disease. I have been astonished at the different aspects borne by a history read before and then after operation; I have chided myself with my own blindness. When such puzzling cases occur, the history should be carefully written on a sheet of paper. At a subsequent visit this should be produced and a second cross-examination indulged in to see that the patient tells the same story over again. We are thus able to verify the original story.

SURGICAL TREATMENT OF GENERAL PARALYSIS OF THE INSANE.

In the *British Medical Journal*, July 23, Drs. McPherson and Wallace, of Scotland, report five such cases in which an opening made through the skull over the oro-lingual centre, and the fluid collected under the membranes was let out. The results are given as follows:

Surgically, all the cases have progressed uninterruptedly to recovery. At the end of eight days the wounds were in every case firmly united, and in none was there a drop of pus. None of the patients seemed to suffer in the least degree from the operation. Undoubtedly, much of the surgical success was due to the able assistance which we from the outset received from Dr. Skeen, assistant physician at the asylum. We are deeply indebted to him for the assiduity with which he carried out all of our directions, the assistance he gave at the operations, and the untiring interest he takes in the after-progress of the cases.

Medically.—In all the cases, with one exception, there was a marked improvement in the mental symptoms, lasting from one to three weeks. This may be fairly accounted for as the result of the operative procedure. We consider that the relief of pressure by the removal of fluid, the greater freedom allowed by the removal of bone for cerebral expansion and pulsation, and, perhaps, the relief of the inflammatory condition by the local depletion of the vessels of the scalp, diploë, and brain membranes, necessitated during the operation, may all have combined to produce the change we noted.

It is significant that concomitant with the cicatrization and increasing density of the scalp and fibrous membranes over the openings there took place a gradual deterioration in the patient's mental and motor symptoms. In Case V, where an attempt was made to drain the pia-arachnoid sac by means of horsehair, the difficulty of preventing rapid healing of the wounds over the horsehair was found to be insuperable, and made its function of draining nugatory. Therefore we are unable to state from our experience whether such a mode of drainage would be beneficial.

We are inclined to regard the removal of subdural fluid a means towards the alleviation of the inflammatory condition of the pial vessels involved, and not the primary object of the operation. In connection with this we have noted that immediately after the operation, and in the after-history of the cases up to the present date, there has been no bulging of the scalp over the openings, which one would naturally have expected from the overpressure of fluid: but, on the contrary, that the scalp has been sucked in, so to speak, and formed a cup-shaped depression. Again, as the membranes have hardened over the openings, the pulsation of the brain has become less and less apparent on palpation. The absence of bulging and pulsation might be accounted for by shrinkage of the brain tissue proper were it not that the depression occurred from the first in cases in which there was no apparent atrophy of the convolutions.

That this cup-shaped depression is not due to adhesion of the scalp to the underlying membranes of the brain we are justified in stating, from the result of the post-mortem examination of Case I, who died three months after the operation, and in whom no such adhesion was found. The absence of adhesion is, of course, fatal to Mr. Harrison Cripps's theory that a lymphatic communication might be established between the membranes of the brain and the scalp tissues.

We regret to record, as the result of our experience, that no permanent or marked benefit was conferred upon our patients by the methods of surgical treatment we were led to adopt in the manner described. In Case III, we believe that the motor symptoms of the disease were, and continue up to this date, relieved

by the operation, but the delusional state is as bad as ever. We do not wish to discourage others from further attempts in the same direction. In our hands the operations proved, from a surgical point of view, eminently successful, and no bad results of any kind were suffered by our patients.

We would remark, finally, that it seems as if the operation, to be of material benefit, should be performed at an earlier stage of the disease than in our cases. In all the cases we trephined, thepathological appearances were such as to lead us to infer that the disease was fully established. We believe that the present state of our knowledge of general paralysis, and our power to diagnose the disease at a sufficiently early stage, is so imperfect that as yet surgical treatment—at all events, by the method adopted by us—can be of no material benefit whatever.

MINERAL WATERS FOR THE GOUTY.

A considerable number of the springs to which gouty patients resort are strongly impregnated with the salts of soda. Now it has been conclusively shown that all the salts of soda act adversely on the solubility of sodium bi-urate and hasten its precipitation, and it may be inferred that the introduction of these salts into the circulation must tend to favor the occurrence of uratic depositions in the body. It is not, therefore, surprising to learn that not unfrequently the first effect of these waters on a gouty patient is either to provoke a downright attack of gout or to aggravate the symptoms under which he was suffering. This event is now recognized by the physicians practising at those spas as a thing to be looked for, and experience has taught them the necessity of caution in regard to the quantity of the waters to be taken by new-comers. They comfort themselves and their patients, however, with the belief that this preliminary storm is a necessary prelude to the calm amendment which is to follow. There is no doubt some foundation for this idea. It is no fiction that a gouty man, tormented with symptoms of irregular gout, is relieved by a regular arthritic attack. I presume that this arises from the complete, or approximately complete, precipitation of the urates floating in his blood and lymph into the structure of the joints. The urates are thereby as effectually removed from the vital fluids as if they were eliminated by the kidneys. It must, I think, be allowed that this is a rough mode of cure, and that it brings with it serious pains and perils of its own. My impression is that gouty persons should either entirely avoid springs which owe their activity to sodium salts or should use them very sparingly. It is difficult to believe that they can do any direct good and easy to believe that they can do direct harm. If they do any good at all, it must be indirectly, by acting on the liver and the intestinal tract; and we possess other means of effecting this purpose without inducing any collateral risk. There are, however, other springs of high and growing repute in the treatment of gout which are not open to these objections. These springs contain no soda or only traces, and the sum of their mineral constituents does not exceed that which is often present in ordinary potable waters. They contain for their principal ingredient a little carbonate or sulphate of lime, and it is very doubtful whether the whole of this is absorbed into the blood. Most of it probably passes out inertly with the faeces. In fact, springs of this class may practically be considered as equivalent to ordinary drinking water, except that several of them have the advantage of being thermal. Among springs of this kind may be mentioned in our own country the waters of Buxton, Bath and Strathpeffers; in Germany the waters of Gastein, Wildbad, Pfeffers and the Sauerling spring at Carlsbad; in France the waters of Aix-les-Bains, Contrexéville, Vittel and Barèges. Now, there can be

no reasonable doubt that the efficacy of these springs has nothing to do with their scanty mineral ingredients, but depends on their watery constituent. They are drunk freely and on an empty stomach. Their action would be to temporarily dilute the blood and lower its percentage of urates and sodium salts. This effect would tend to retard or prevent uratic precipitation, and thus give the defective kidneys additional time to overtake their arrears in the task of eliminating uric acid.—Sir W. Roberts, *Lancet*, July 16.

AN ADDITIONAL METHOD FOR RESUSCITATION IN DROWNING.

In a translation from *Le Bulletin Medical*, the *Cincinnati Lancet-Clinic* presents the following suggestions of M. Laborde:

The procedure, said he, consisted in forcibly drawing out the tongue, in pressing the jaws apart, and in pulling the tongue forwards and backwards in an energetic manner. The effect and the importance of this maneuvre consisted principally in the powerful action that the excitation of the base of the tongue and of its traction exercised upon the reflex respiratory system. This traction can, moreover, be made in a regular manner, in adapting itself in some measure to the succession of motions of the function that it is to revive.

The idea of the employment of this procedure so simple had been suggested to him by an experimental remembrance. When in the laboratory we see an animal in a state of syncope or accidental asphyxia during an experiment, notably after chloroform or chloral anæsthesia, at the same time that we are getting ready to apply electricity and to make artificial respiration, our first care is to seize the tongue not only as the surgeon does to relieve the opening to the pharynx and larynx, but also to make tractions upon it, repeated and rhythmical, which often suffice in themselves to provoke a return of the respiration, after a series of loud hiccoughs, at first passive—that is to say, only responding to the provocation and soon becoming spontaneous. In order to seize and to hold the tongue well, the hand is the only resource, as the tongue slips with great facility, as we well know, and especially in the case of accident, like that we are speaking of. It is the best and surest means to accomplish what we desire, especially if we are armed with a spoon to keep the mouth open and to press upon the base of the tongue. It is well to put a handkerchief around the fingers to prevent as much as possible the slipping or escape of the tongue, and one need not be afraid to hold the tongue firmly and to pull on it with some force.

Such is the procedure, of experimental origin, which, he desired to repeat, had been marvelously successful in his hands, and which had been referred to nowhere else.

ULCERS OF THE TONGUE.

In the discussion of a paper read before the American Surgical Association, Dr. D. W. Cheever, of Boston, referred to the question of diagnosis of ulcers of the tongue: In the first place we have dyspeptic ulcers. These appear in successive crops. They are not indurated and can be made to heal by simple treatment. Secondly, we have the syphilitic ulcers. Previous history is at times of service. In doubtful cases two weeks of anti-syphilitic treatment should be employed. Third, lupus or tubercular disease; this is not so common as cancer. The test of the examination for the bacillus is not always successful. The tubercular ulcers form and reform; some heal and leave scars. Cancer does not heal, but goes on extending. In lupus the sub-lingual and sub-maxillary glands are early infected. True cancer is almost always at the side of the tongue; the infection of the glands is usually speedy.

While he advised removal of enlarged glands he did not think that the neck should be treated as the axillæ. As to duration, he thought that malignant affections of the mucous membrane are more speedy in their recurrence than malignant affections in the skin and glandular structures. In cancer of the tongue the disease, as a rule, recurs in four to six months. In simple cancer of the tongue without gland involvement, preliminary tracheotomy is not needed. He operates with the patient in the sitting position and not thoroughly etherized. He had never tied the lingual artery for cancer. The partial amputation of the tongue where the disease is limited seems to have been as successful as the total removal. Recurrence is almost always in the glands and rarely in the stump. Reference was also made to the remarkable recovery of the power of talking in cases where the tongue was completely removed.—*Northwestern Lancet.*

DIURETIN.

Professor Demme, in a clinical report of the Berne Children's Hospital, mentions that he has successfully employed the so-called diuretin or salicylate of theobromine and sodium in several cases of dropsy, in which calomel and hot baths did not seem suitable and where ordinary diuretics had not proved beneficial. He finds that it may be regarded as a safe drug for children above a year old, and one that is quite free from unpleasant effects. He believes the diuretic effect is occasioned mainly by action on the renal epithelium. In scarlatinal nephritis severe dropsy coming on after the acute stage of nephritis is more easily reduced by diuretin than by any other means. In cases of mitral insufficiency, with insufficient compensation, ascites and anasarca are best combated with the help of diuretin after the compensatory disturbance has been reduced by digitalis. As to dosage, children from two to five years of age may be ordered from eight to twenty-five grains during the day, and children of from six to ten years as much as from twenty-five to forty-five grains, in divided doses, of course. The total amount for the day is generally dissolved in four ounces of water, with ten or twelve drops of brandy and forty grains of sugar. In some cases the administration was continued for some weeks without any signs of either a cumulative action or of diminished therapeutical effect being seen. In one of the cases of scarlatinal dropsy, of which details are given, the effect of diuretin was very striking. While the child was upon acetate of ammonia the urine amounted to only nine or ten ounces a day, and contained 0·15 per cent. albumen, according to Esbach's scheme of measurement, with a considerable number of granular casts and epithelium undergoing fatty degeneration. The change of treatment produced an immediate effect, the urine in the three days amounting to nearly three times the quatity previously measured and containing only half the former quantity of albumen, with very few casts, and in a week neither albumen or casts could be found.—*Lancet.*

SYMMETRICAL INFLAMMATION OF LACRYMAL GLAND.

At a recent meeting of the London Ophthalmological Society, July 8th, Mr. Simeon Snell communicated a paper on a case of Symmetrical Dacryo-adenitis. The patient was a married woman aged thirty-six, who came under observation on March 22nd. Ten weeks previously the right eye became inflamed; this was soon followed by a swelling beneath the upper lid, which gradually increased and was accompanied by pain. A similar condition on the left side had begun a week before she came to the hospital. Both lacrymal glands were enlarged, hard and tender to the touch, the right being much more affected than the left. The history threw no light upon the cause of the disease. In spite of the

absence of evidence of syphilis, iodide of potassium was given (five grains) three times a day and was rapidly followed by subsidence of the swelling and other signs. During the time the lacrymal glands were decidedly enlarged there was an almost complete absence of tears on the right side and a noticeable diminution in their secretion on the left side.

Medical Items.

Dr. T. Mitchell Prudden, of New York, has been appointed Professor of Pathology in the Medical School of Columbia College.

It is officially announced by the authorities of the St. Petersburg Military Medical Academy that stammering will in the future be considered a disqualification in candidates for admission.

The use of the London fog has been discovered. It acts as an antiseptic through the sulphurous acid it contains—so says the President of the Institute of Civil Engineers.

It is said that the Illinois State Board of Health will not accept a death certificate bearing the words "heart failure." It wants more definite information as to the cause of death.

The late Dr. D. Hayes Agnew, of Philadelphia, left an estate valued at $250,000. He bequeathed to the University of Pennsylvania $50,000, his work on surgery, library, and anatomical collections.

The governors of the Rotunda Lying-in Hospital, of Dublin, have resolved to build an additional wing to the institution, and several of them have subscribed liberally to the object. Last year a bazaar was held to obtain funds, but a sum of £4,000, in addition to what was then realized, will be required. This extension will add considerably to the efficiency of the institution.

In Germany, a lecture on homœopathic medicine is added to the curriculum of the regular schools, and in that country the distinctive school of homœopathy is as thoroughly done away with as could be wished. The latest statistics give only thirty-seven homœopathic practitioners in the whole of Germany.—*Canadian Practitioner.*

Harvard Medical School has adopted a compulsory four years' course which will be required from all who enter next fall. Students in classical and scientific schools in which courses in anatomy, physiology and chemistry are taught will be admitted to advanced standing on passing an examination.—*Canadian Practitioner.*

Professor Henoch, the celebrated specialist for diseases of children, has just celebrated the fiftieth anniversary of the taking of his degree. His professorship in the Berlin University dates from 1858, and since 1872 he has been director of the clinic for children in the Charité Hospital. Professor Henoch, who is now aged 72, is in full possession of his strength, both bodily and mental, and carries on a large consulting practice.

The New York Board of Education has appointed a corps of experienced physicians to examine the physical condition of all graduates of the Normal College who apply for positions as teachers in the public schools. The fee for such examination is three dollars. Unless this examination is satisfactorily passed, no appointment is given.

The Court of Appeals of Kentucky has recently decided that syphilis, pleaded in answer to an action to recover damages for breach of promise of marriage, is a complete defence, following the decision of the Supreme Court of the State of North Carolina, in which the same defence was interposed and sustained in a similar action.—*Weekly Medical Review.*

Perchloride of iron as a remedy in typhoid fever has been brought prominently forward by Dr. I. Anderson, of Edinburg. His treatment consists in administering five drops of the solution of perchloride of iron in a little water with glycerin or syrup, and a few drops of tincture of ginger every hour, day and night. If the patient has nausea, this is relieved by four-grain doses of subnitrate of bismuth, given before each dose of perchloride of iron. He states that the diarrhœa and fever will disappear rapidly under the influence of the perchloride of iron, at the end of five days if the treatment has been commenced within two or three days after the onset of the fever, at the end of ten days if it is a case of medium severity coming under treatment before the end of the first week. The remedy should be continued at least a week after the complete cessation of the fever. Dr. Anderson has used this treatment for several years, and has not lost a single case where the administration of the perchloride was commenced in time. —*American Lancet.*

The Brooklyn Medical-Book Club was organized March 5, 1892. The membership, which is already complete, is limited to twenty. A Purchasing Committee consisting of the President, Dr. J. T. Conkling, Secretary, Dr. F. H. Stuart, and Dr. J. H. Hunt, will select the books to be purchased. The members of the club will send to the Secretary the titles of any books they desire to be purchased either such as they wish to consult or as they think valuable for the medical library. No books which would be duplicates of those already in the library will be purchased. The books are to be deposited, with the permission of the Council, at the library of the Medical Society, whence they may be taken by the members of the club for reading at their own homes. Books may be retained, when thus removed, for two weeks. At the end of the year it is proposed to donate the books to the library of the Society, the club retaining for its members the right at any time to consult the books purchased by the club at their own homes, in the same way as before such donation.—*Brooklyn Medical Journal.*

The Mississippi Valley Medical Association will hold its Eighteenth Annual Session at Cincinnati, Wednesday, Thursday and Friday, October 12, 13 and 14, 1892. An excellent program, containing the best names in the valley and covering the entire field of medicine, will be presented. An address on surgery will be delivered by Dr. Hunter McGuire, of Richmond, Va., President of the American Medical Association. An address on medicine will be made by Dr. Hobart Amory Hare, Professor of Therapeutics and Clinical Medicine, Jefferson Medical College, Philadelphia, Pa. The social as well as the scientific part of the meeting will be of the highest order. The Mississippi Valley Medical Association possesses one great advantage over similar bodies, in that its organic law is such that nothing can be discussed during the sessions save and except science. All ethical matters are referred, together with all extraordinary business, to appropriate committees—their decisions are final and are accepted without discussion. The constitution and by-laws are comprehensive and at the same time simple. Precious time is not allowed the demagogue or the medical legislator. The officers of the Pan-American Medical Congress will hold a conference at the same time and place. Charles A. L. Reed, M. D., Cincinnati, President; E. S. McKee, M. D., Cincinnati, Secretary.

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CONTENTS

ORIGINAL ARTICLES.

A Selection of Cases of Throat and Nasal Diseases from Unsuspected Causes. By William T. Cathell, M. D., Baltimore. . . . 925

Reports from Leopold's Clinic. No. I.—A Normal Obstetrical Case. By William S. Gardner, M. D., Baltimore. 929

EDITORIAL.

The Dispensary-Abuse Problem in London. . 932

The Need of Clearness. 933

REVIEWS, BOOKS AND PAMPHLETS. . . . 933

MEDICAL PROGRESS.

Nature and Sequels of Acute Pneumonia.—The Moral Side. — Obstructive Jaundice. — The Mamma.—Insomnia in an Infant.—On Missed Abortion.—The Symptoms of Tumor of the Pineal Gland.—What Lies Back of Her Hysteria?—Amputation in Diabetics.—Diagnosis of Diabetic Coma.—Unusual Action of Atropine and Homatropine on Infants' Eyes.—The Chorea of Pregnancy.—Variability of Disease-Germs.—Self-Mutilations by General Paralytics.—Radical Cure of Urethral Stricture.—The Etiology of Typhus.—Use of Nitrate of Silver in Urethral Inflammations. . . . 935

MEDICAL ITEMS. 946

Original Articles.

A SELECTION OF CASES OF THROAT AND NASAL DISEASES FROM UNSUSPECTED CAUSES.

BY WILLIAM T. CATHELL, M. D., BALTIMORE.

The following eleven cases are selected and written up from my case book to illustrate the diversity of cases met, and popular errors regarding their nature and cause, to which is added the treatment pursued.

CASE I.—Mollie L., a handsome miss of 23 years, consulted me in February last for what "everybody" had told her was "catarrh of the head" of several years' duration, for which she had used a roomful of "sure cures." Her nostrils were crusted and smeared with decomposing nasal secretions, that made her breath fetid enough to disgust a buzzard.

Exploration of nasal cavities with Mackenzie's illuminator revealed a scrofulous ulceration of the pitnitary membrane of both inferior turbinated bones, portions of which were denuded and ulcerating—in short, a genuine case of ozæna. The necrosed bones were curetted, and are being treated by the nightly introduction of greased tampons of iodoform (10 per cent.) made of cotton charpie, followed in the morning by irrigations of menthol, thymol, eucalyptol, etc., and the usual general treatment, with attention to hygiene.

The fetor seems gone, and after fifteen weeks' attendance distinct improvement is noticeable.

Case II.—This is almost the reverse of the last case. Hattie T., High School girl, aged 18 years. Difficulty in the throat and nose for more than a year, for which she did not consult a physician, for fear he might say her symptoms—excessive secretions from nose, obstructed nostrils, dropping of fluid into the throat, dulness of hearing, a disagreeable breath, etc.—were the forerunners of ozæna, to which an aunt of hers was a martyr.

Examination revealed that she had an ordinary case of chronic nasal catarrh with hypertrophied tonsils, which proved somewhat tedious, but finally yielded to atomization with Dobell's solution, plus listerine, alternated with cotton tampons of hamamelis, using also alterative tonics internally. The fetor of her breath was due chiefly to accumulation of cheesy secretions in the crypts of tonsils which had undergone putrefaction.

Case III.—Alexander S., aged 19 years, apprentice in iron foundry, cachectic looking, subject to noisy mouth-breathing, nasal twang of voice, dulness of hearing, restless snoring sleep, night sweats, lack of appetite and strength; was brought by his father, who attributed his impairment to cigarette smoking and the dust of the foundry.

An examination showed a sufficient degree of soft variety of hypertrophied tonsils to induce all the symptoms.

The use of Fahnestock's tonsillotome followed up with ten-grain doses of salicylate and benzoate of soda, alternated several times a day, until inflammatory process was subsiding, and then only continued in small quantities, removed all symptoms except deafness, which I now think is due to other causes.

Case IV.—C. W. D., salesman, aged 41 years, had suffered annually for five or six years with what he called "summer sore throat." He had been vacillating from one physician to another, and a great variety of agents consequently were used, under different theories, without beneficial results.

Examination revealed an inflamed and abraded condition of pharynx, epiglottis and upper portion of larynx, which resembled the effects of caustic potash. After he had made me several visits, I accidentally learned that he was in the habit of daily sprinkling salt on three or four large tomatoes and eating them as one would an apple. The caustic action of the tomato acid and salt, on his sensitive mucous membrane, doubtless caused all his trouble, for, after they were prohibited, the lesion, which had formerly resisted every treatment, yielded rapidly.

Case V.—Willie K., aged 33 months, had, for eight months, oral-breathing, restless sleep and sore throat, which his aunt had been treating for worms.

An examination showed that his right nostril was occluded, high-up, by a large, flat red bean, which could be felt with the probe, and also be seen by the illuminator.

Dr. Dodd's ingenious method, which consists of introducing a tube into the free nostril, and blowing suddenly into it, so as to cause a strong pressure of air back of septum, behind foreign body, was tried, but in this case it failed.

Finally the bean, which had become greatly swollen, was removed with a fine pair of alligator nasal forceps, aided by a tenaculum. Being large, and the patient a child, anæsthesia was necessary. After the operation the symptoms disappeared promptly, proving that the bean originated all his trouble.

Case VI.—Mary R., aged 23 years, married, no children, recently consulted me for a sore throat, which had been ascribed to wearing a rubber plate.

Examination revealed two circular mucous patches, situated symmetrically on the anterior pillars of fauces; also a ragged yellow ulcer behind left tonsil, looking as if a piece had been scooped out; also another on veil of palate. Believing that they were specific, in spite of her innocent protestations to the contrary, I determined to know the truth, and sent for her husband, who, upon accusation, frankly confessed that he may have communicated the disease to her. Under the topical use of chromic acid (2 grs. to 3) by means of aluminium probe armed with a tuft of cotton, alternated with corrosive chloride applications and the usual internal treatment, her case was very gradually gotten under control.

Case VII.—J. W. S., aged 32 years, traveling salesman, whose time is spent in the open air, had suffered from early manhood with incessant tickling cough, bad taste in mouth, gagging, and even vomiting of food, which had been ascribed to "nervous dyspepsia."

Examination revealed a uvula at least an inch long, with a bulbous tip, which titillated the base of the tongue and epiglottis, and originated all his suffering.

Astringent treatment by means of Sass' spray tube, with which compressed air was used. The trouble not yielding, uvulotomy was done, thus giving instant relief from titillation; after the wound healed but little further treatment was required.

Case VIII.—William J., a youth, aged 19, came under my care with an œdematous uvula and inflamed pharynx, which an ignorant pretender had produced by applying a caustic solution of nitrate of silver to the perfectly natural large circumvallate papillæ, on the base of his tongue, under the ignorant belief that they were warts of venereal nature.

The patient experienced great mental relief on learning that they naturally belonged there, and the mischief the fellow had done was soon mended by applying with a camel's hair pencil, biborate, benzoate and bicarbonate of soda in solution.

Case IX.—James B., grocer, aged 27, had suffered with complete occlusion of right nostril and also at times of left one, for two or three years, voice false and rattling, with sounds of fluid in the nose, lachrymal apparatus and neighboring conjunctiva red and irritable, for which he had often smoked "cubebs," believing he had asthma.

Examination showed a crooked nose and deflected septum, with polypi in right nasal fossa, which caused obstruction from pressure of opposing surfaces, making a shallow ulcer on the septum at the point of contact.

The greater portion of each was removed at four sittings, with weekly intervals.

The septum was treated as recommended by Seiler, consisting of punching the deviated portion with the star knife-blade forceps, and then forcibly correcting the deformity with Adams' instrument, devised for the purpose, after which an antiseptic nasal wooden plug was allowed to remain in the formerly obstructed nostril for 36 hours.

His nose has remained free from any recurrence of the disease and no inconvenience of any kind has been experienced since the operation except that the nose is still crooked and the voice slightly nasal.

Case X.—William W., aged 23 years, came under treatment for what impressed him as "catarrh and throat consumption," which he attributed to measles in childhood. His nostrils were so obstructed that he was unable to blow them: mouth-breathing, nasal voice, hacking cough and the so-called frog-faced expansion, represented by the following:

Picture of a Mouth-breathing Boy.

Examination with the speculum and rhinoscope revealed that the mucous membrane of nasal passages was hypertrophied and studded with small polypoid growths, which caused distressing sneezing, and bled readily when roughly touched. One, as large as a raspberry, of a dark red color, could be seen and felt in the naso-pharyngeal space, attached by a short pedicle to the posterior middle turbinated bone.

Treatment: Probe-pointed soluble nasal bougies of biborate of soda in cocoa butter were introduced. Also quinine and nux vomica before and syrup iodide of iron after every meal.

When he was again able to breathe through his nostrils, sneezing, which became a persistent and annoying symptom, was prevented or aborted by applying a solution of camphor in spiritus ammoniæ aromaticus at the moment the sense of sneezing began.

The growth in the naso-pharynx was removed with Jarvis' snare, the patient being placed on a table with the head hanging vertically back over the end of it, thus making it comparatively easy to introduce a mirror into the vault and see every part of it, and to manipulate instruments.

The patient was being benefited when, at the end of seven weeks, he grew careless, and abandoned treatment.

CASE XI.—James McG., aged 24 years, unmarried, who had been five months in the hands of a pretender for what he termed "throat consumption," consulted me five weeks ago. Anæmic, low spirited and annoyed greatly by the sensation of a fluid dropping from nose to throat, with a bad taste, that he feared might create a permanent fetid breath.

Rhinoscopic examination showed chronic nasal catarrh bordering on the hypertrophic, with some follicular pharyngitis and relaxation of palate.

Nostrils are being treated with applications of ferric alum (10 grains to ℥) alternated with Boulton's solution by means of atomizer, under which he is doing well.

Errors similar to the above are encountered almost daily, and force one to regard correct diagnosis as the corner-stone of all rational treatment.

REPORTS FROM LEOPOLD'S CLINIC.

NO. 1.—A NORMAL OBSTETRICAL CASE.

BY WILLIAM S. GARDNER, M. D.,

Attending Obstetrician Maternite Hospital, Baltimore.

When a patient is admitted to the obstetrical department of the Frauenklinik, under the direction of Leopold, at Dresden, a record is made of the answers to the following questions:

Personal Record.—What is your name, age, and are you married or single? Where were you born, what is your religion, and what was your last place of residence? Have you had measles, scarlet fever, enlarged glands or rachitis? At what age did you learn to walk? (This last question is asked to bring out, if possible, the very frequent history of rachitis. If the woman learned to walk so late in life that she remembers when, she probably had rachitis in early childhood, and this may have affected the diameters of the pelvis.) What was the time of your first menstruation, frequency, duration and amount of subsequent periods? What serious illness have you had since beginning to menstruate? Give a brief account of former pregnancies, confinements and puerperal periods.

Special record of present pregnancy.—What is the number of this pregnancy? What was the date, duration and amount of your last menstruation? If known, what was the date of conception? Date of quickening? Date of lightening? Were you examined before coming into the hospital, and if so, by whom?

Then comes the physical examination, record being made of the following points:

General condition of the body.—Height, pulse, temperature; condition of muscles, skeleton, heart, lungs and urine; signs of syphilis or other existing diseases.

Pelvic Measurements.—Distance between the spines and crests of the ilium; the trochanters; external conjugate; the internal conjugate (the latter only measured when the external conjugate is below the average.)

Genital organs and other parts influenced by the pregnancy.—The condition of the mammary glands and nipples; the circumference and markings of the abdomen; condition and height above the symphysis of the umbilicus; condition of the abdominal wall; the condition of the thighs, feet, labia and perineum; the condition of the body, cervix, internal and external os of the uterus; the condition of the walls, color and secretions of the vagina.

Examination of fœtus.—The position of the back, limbs, neck and head. The diagnosis from these of the position and period of pregnancy; the position and frequency of the fœtal heart sounds; the position of the uterine souffle; the quantity of amniotic water; the mobility of the fœtus.

After so careful an examination as this has been made the experienced attendant has quite a definite idea of what course the labor is likely to pursue.

Management.—When the patient is first admitted she is taken to the bath-room and thoroughly scrubbed. I use the word "scrubbed" purposely, because to say simply that "she is given a bath" is expressing much too mildly the process that she is put through. She is then dressed in fresh clean clothes belonging to the hospital. If she remains long before her confinement the bath is repeated twice each week. When the labor commences the patient goes again to the bath-room; the scrubbing is repeated; the hair about the vulva and mons veneris is clipped short with scissors; the external genitals bathed thoroughly with a 1-2000 corrosive sublimate solution, and the rectum emptied by an enema. The patient is then taken to the confinement room and placed on a high bed. The bed-frame is of iron, and on rollers with rubber tires, so that the bed can be easily and noiselessly placed in any desired position. The mattress is in three sections, and covered completely with a large rubber sheet. The covering for the patient is identical in pattern with the split sheet that has been in use at the Maternite in Baltimore for several years, but is considerably heavier.

If the labor is not complicated a vaginal examination is not made at all, but the patient is examined very carefully externally. The physician or midwife who makes the examination and attends the patient wears a sort of white linen apron that fits closely about the neck, hangs nearly to the feet and has short sleeves that reach about half way from the shoulder to the elbow. From the end of this sleeve the arms are completely bare.

By palpation the presentation, position, progress of labor and the relation of the size of the head to the size of the pelvis are made out. This latter point is naturally the most important observation connected with the labor. Very frequent examinations are made of the fœtal heart sounds and note is especially taken of their position and quality.

If much urine accumulates in the bladder it is drawn by a flexible male catheter. These catheters are kept constantly ready for use, immersed in a 1-2000 corrosive sublimate solution. Before the catheter is passed the orifice of the urethra and the neighboring mucous membranes are carefully wiped with a bit of cotton saturated with a 1-2000 corrosive sublimate solution.

In nearly all cases the bag of waters is allowed to rupture spontaneously. After the amniotic water has escaped, the external genitals are bathed by running a stream of 2½ per cent. carbolic acid solution over them. This is repeated at any time during the labor if blood or water should escape from the vagina.

The perineum is protected by endeavoring to induce the woman not to bear down during the last pains, and by retarding the advance of the head by pressing firmly on the occiput with the tips of the fingers of the left hand, while the right hand is held in position to keep the head from bursting suddenly through the middle of the perineum. Very little pressure is made with the right hand unless really necessary. After the head is born the body is supported to prevent it from bearing too heavily on the perineum. The external genitals are again washed and the patient allowed to rest quietly for an hour; the uterus in the meantime being carefully watched to see that it does not unduly relax. If the placenta is not expelled spontaneously at the end of that time it is extracted by the Crede method.

The perineum is examined by separating widely the vulvar tissue by means of cotton pledgets saturated with a 2½ per cent. carbolic acid solution and held by large, strong metal sponge-holders. If there is only a slight rupture it is dusted with iodoform; if there is any considerable rupture it is brought together with silk stitches.

The puerperal period is considered a purely physiological condition and is allowed to pursue its course with the least possible interference. After normal labors neither vaginal nor intra-uterine injections are used unless positively indicated by some secondary condition.

Dresden, July, 1892.

FOREIGN BODY IN THE AIR-PASSAGES FOR FIVE MONTHS.

Wilson (*Glasgow Medical Journal*, July, 1892, p. 24) has reported the case of a man, twenty-eight years old, in which a whistle, made of a circular piece of tin, perforated at the centre and folded on itself, measuring at its base one and a half inches, and transverely three-quarters of an inch, was inspired into the trachea. Respiration was somewhat obstructed, and a peculiar metallic wheeze was heard on sudden expiration. Examination, however, failed to detect the situation of the foreign body. For five months the man suffered comparatively little inconvenience. There was dysynœa on exertion, and occasionally a sense of discomfort at the level of the upper portion of the sternum. On cough, the body could be felt to move. Sleep was disturbed by a sense of fear. One morning the man awoke with a tickling sensation in the throat, and, on coughing, the whistle was ejected.

A hospital for consumptives is about to be erected in New York at a cost of over $300,000. It is to be called the Seton Hospital, and will be under charge of the Catholic Order of Sisters of Charity.

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BALTIMORE, AUGUST 20, 1892.

Editorial.

THE DISPENSARY-ABUSE PROBLEM IN LONDON.

This burning question, which has only recently excited serious attention among us, received in London very grave consideration as long as forty years ago. At that time numerous conferences were held among physicians touching the matter, and series of fruitless resolutions were passed. A practical attempt was made to correct the evil by the establishment of provident dispensaries for persons of small means; but these dispensaries are generally avoided in favor of those in which a smaller charge or no charge at all is made.

In January, 1892, the Committee on Medical Charities of the British Medical Association appointed a sub-committee of three to obtain from each hospital and dispensary in London which has an out-patient department a statement of the methods used to limit its benefits to those who are unable to pay their private medical attendants. The results of these investigations are published in the *British Medical Journal*, July 23, 1892. Circulars of inquiry were addressed to 171 such institutions, and 94 replies were received. Visits of inspection were paid to 14 hospitals. It was found that in but two of the hospitals were efficient means provided for the exclusion of well-to-do applicants, especially those with special diseases, who declared that they were unable to pay specialist's charges. The dispensaries not connected with hospitals generally reported that they had a system of inquiry.

The committee recommends among other precautions: That an inquiry officer be attached to every hospital, who shall inquire into all doubtful cases. That no members of clubs, provident dispensaries or medical aid associations, be treated, except upon letter from the medical attendant of the society. That notices be placed in the dispensaries explaining that the dispensary is a charity, and that applicants must state means of livelihood and amount of wages. That the general practitioners of each neighborhood should combine for the purpose of

supplying medical attendance and medicines to working-people unable to pay the usual fees, who would otherwise go to prescribing druggists and untrained doctors. That the annual report of each medical charity should contain an account of the means it takes to prevent imposture, and a statement of the number of persons refused on these grounds, and the special reasons for such refusal.

These valuable suggestions are to be submitted to the British Medical Association at its next meeting. They are eminently worthy of consideration by our American medical charities.

THE NEED OF CLEARNESS.

Hand in hand with the discovery of new facts in medicine there should ever go a spirit of questioning in regard to those things which have been popularly accepted as already proven. At one extreme of error stands the chronic skeptic, who does not believe what has been sufficiently demonstrated; at the other extreme, the man of credulity, who swallows whole (without tasting or mastication) whatever is alleged to be true. The mean between these is the Scripture rule, "test every thing, and when you find it good hold on to it."

There are many popular beliefs, held both by physicians and by the laity, which blind the eyes of careless observers to the real causes of disease. The time-honored "milk fever" is a striking example. How often must the inception of fatal puerperal sepsis have been overlooked under the delusion that the fever was due to the "coming of the milk."

One of the most interesting tasks in our most interesting life-work is the unraveling of the thread of causation in obscure febrile attacks which, affecting a previously healthy person, recur again and again, at short but irregular intervals, soon after the patient has changed his abode or boarding place—as when he goes to the mountains or seaside in the summer. The trouble will perhaps be ascribed by the patient to a recrudescence of some "malarial" tendency left in the system from a fit of fever and ague which occurred several years before. The cautious physician will, however, seek for the cause of the attacks "nearer home." The illnesses will suggest repeated infections from some present source of sepsis. He will perhaps find insanitary conditions of food or drink or housing which will explain the whole trouble. Or he will observe that a change of residence, even to a neighboring house, will be followed by rapid convalescence. On the other hand, a blind acceptance of the "malarial tendency" theory may expose his patient to irremediable injury.

While not denying the existence of predisposing conditions of body, the physician should be ever watchful over the immediate causes of disease.

Reviews, Books and Pamphlets.

Deafness and Discharge from the Ear. The Modern Treatment for the Radical Cure of Deafness, Otorrhœa, Noises in the Head, Vertigo, and Distress in the Ear. By SAMUEL SEXTON, M. D., assisted by ALEXANDER DUANE, M. D. J.H. Vail & Co., publishers, 1891.

This little book of 89 pages is a well-written and strong plea for the operation of excision of the drumhead and ossicles—particularly the malleus and incus—in cases of deafness from dry aural catarrh, or of purulency of the middle ear, which has resisted the other methods of treatment. There are a number of other cases of each kind given in detail, most of them showing marked benefit or entire cure. With the exception of some of the cases there is nothing in the book which has not previously appeared either in Sexton's "The Ear and its Diseases," or journal articles by this same writer or Burnett. The description of the operation is by no means as full or satisfactory as that in Sexton's larger work. As regards dry aural catarrh, the author states, what every aurist of experience knows, that the usual methods of treatment do no good in the great majority of cases; that the trouble lies in the conducting mechanism in the middle ear, and that by the operation aerial vibrations are brought into direct contact with the stapes in the oval and the secondary membrane in the round windows, thus improving the hearing if there exists no secondary internal ear trouble; that the operation itself is free from danger, and the earlier it is done after deafness is observed, the better the prognosis.

In suppurative cases the remnants of the drumhead and ossicles may be necrotic, and be themselves the cause of the chronic purulency; they may make drainage impossible, as in attic suppuration; they may conceal polypi or other recognized causes of suppuration; they may prevent medication of the tympanic mucosa. In one or all of these cases their removal is necessary to effect a cure. It is safe to say that there will be a number of investigators before long in this new field of aural surgery, and that clinical experience will prove or disprove the value of the operation.

The Transactions of the Second Annual Meeting of the Association of Military Surgeons of the National Guard of the United States. Held in St. Louis, April, 1892. St. Louis, Becktold & Co., 1892.

This very creditable volume contains many thoughtful articles, both on the surgical and on the sanitary necessities of military life. Among those of the latter class we are especially interested in an essay upon the dangers of stationary camps, by Assistant Surgeon C. L. Lindley.

University of Maryland Eighty-Sixth Annual Circular of the School of Medicine, N. E. corner Lombard and Greene Streets, Baltimore, Session 1892-93.

Alumni of the college and others desiring to receive the circular regularly are requested to send their names and addresses to the Dean, Dr. I. E. Atkinson, 605 Cathedral Street.

Medical Society of Franklin County, Pennsylvania. Its History and Sketches of the County. By JOHN MONTGOMERY, M. D., of Chambersburg, Pa. Published by the Society, Chambersburg, Pa., J. R. Kerr & Bro., printers, 1892.

All honor should be given to every effort put forth by men of the present generation for the preservation of the memory of those physicians who, with public spirit and generous emulation, have sought in the past to serve and elevate their profession, as one of the great callings by which the work of the world is advanced. In the pamphlet before us Dr. Montgomery has ably performed this tribute to the memory of the pioneers of Franklin County. His memorial is all too brief, yet without it many an honorable name would soon have been forgotten.

An Epitomized Review of the Principles and Practice of Maritime Sanitation. By JOSEPH HOLT, M. D., former President of the State Board of Health, 1884-1888. New Orleans, L. Graham & Son, printers, 44 and 46 Baronne St., 1892.

Gynæcological Technique. By Howard A. Kelly, M. D., Professor of Gynæcology and Obstetrics in the John Hopkins University. Reprinted from *New York Journal Gynæcology and Obstetrics*, July, 1892.

Medical Progress.

NATURE AND SEQUELS OF ACUTE PNEUMONIA.

In the *Lancet*, July 23, Dr. Auld, of Glasgow, writes:

In this disease, then, to be regarded as a genuine inflammation? Inasmuch as no changes occur in the connective-tissue cells of the alveolar walls, the process can only be regarded as superficial, the local expression of a general disease. It is this absence of germination in the fixed tissue cells which is the sole anatomical distinction between acute pneumonia and acute broncho-pneumonia. I have elsewhere compared the pulmonary lesion of acute pneumonia to the joint lesion of acute rheumatism. As the former differs from broncho-pneumonia, so does the latter from acute synovitis. It is alleged—as for instance by Sturges and Coupland—that hepatizations of lung exist resembling that of acute pneumonia, which are in fact secondary to other diseases or own but a mechanical origin. But such cases are to be suspiciously regarded, and I am inclined to think that they are mostly genuine pneumonias, modified no doubt by the peculiar circumstances under which they occur.

Now as to the issues of this affection. Passing over destructive softening of the lung, abscess formation and gangrene, there remain two conditions which are no doubt rare, and consequently ill-understood, but which are none the less highly important. One is somewhat vaguely termed "delayed resolution." By this it is implied that dulness, râles and deficient breathing persists over a greater or less area of lung after the complete subsidence of all acute symptoms. This condition may be present for weeks or months, and yet the lung may gradually "clear up" and become restored to health. This is an occurrence of considerable rarity, and, according to Wilks, in ninety-one cases out of a hundred in which dulness persists after pneumonia it is due to pleurisy. In many cases there is no doubt empyema; but post-mortem cases are likewise found showing persistent pulmonary consolidation, the air cells containing granular fibrin, mucous flakes and fatty cells, and the alveolar walls being lined with several rows of spindle cells. In such cases there is absence of interstitial changes, at least at first. If, however, complete recovery does not take place, there remain two other possibilities. The hepatized area may break down into small abscesses, and a form of phthisis is set up, or else the lesion contracts in area and cicatricial changes ensue, leading to a fibrous node, which becomes ultimately buried in emphysematous tissue.

The other issue of pneumonia to which I refer is in induration. Not, strictly speaking, in induration of the lung, but in induration of the pneumonic lung. The first step in this process is the germination (atypical to the disease) of the connective-tissue corpuscles of the alveolar walls. Next, the fibrinous exudation (never the corpuscular) becomes organized. To this form of induration I have applied the term "fibroid pneumonia," for reasons which it is impossible here to discuss. Easily recognized at first, this remarkable transformation of the pneumonic products exhibits changes both of growth and of decay. To trace microscopically the evolution of fibroid pneumonia from its inception to its various terminations is a task of considerable difficulty. Outwardly indeed, and to the

naked eye this lung is sufficiently distinguished from Corrigan's cirrhosis in its bulky character and the comparative absence of bronchiectasis. Further, it is found as an independent affection not consecutive to an acute pneumonia. But many cases of what is termed chronic pneumonia or interstitial pneumonia or Clark's phthisis, are in reality advanced cases of this fibroid pneumonia. No doubt this statement may be criticised and questioned, but it is none the less capable of proof, direct, continuous and complete.

THE MORAL SIDE.

In an address before the Marion-Sims College (*Alienist and Neurologist*, July, 1892) Dr. C. H. Hughes says:

The study of the physician includes the moral as well as the physical well-being of man, for the purity of the soul has much to do with the health of the body. The purity of the heart and the dominance of the body by principles of rectitude has much to do with the health and consequent happiness of present and succeeding generations. The direct and hereditarily entailed diseases which are the offspring of sin, and *vice versa*, which have filled and are filling the land with misery and woe, both physician and divine are alike especially interested in preventing. The psychology of sin and the pathology of crime are studies alike for doctor and divine.

The man who is sick in his soul is seldom well in his body, and the soul's affairs do not prosper well when the body is disordered.

Like the divine, the physician may also aid in healing "the wounded in spirit and the broken-hearted," and in "binding up their wounds." He may "minister to a mind diseased," and "with sweet oblivion's antidote cleanse the stuffed bosom of that perilous stuff which weighs upon the heart." He does this effectually through the modern successful management of melancholia.

OBSTRUCTIVE JAUNDICE.

Dr. Vaughan Harley presented to the Section on Pathology of the British Medical Association, which met in Nottingham in July, an enquiry into the pathology of this interesting condition. In this communication, which embodied the results derived from a long series of chemical, pathological and experimental biological researches on the antagonistic effects, from a jaundice point of view, of ligaturing both the thoracic and common bile-ducts in animals, the author said the following justifiable conclusions might be drawn: 1. That, contrary to the accepted pathological doctrine, the bile which is eliminated by the urine and deposited in the skin and other tissues in cases of obstructive jaundice does not find access into the general circulation of the blood-capillaries at all. 2. In cases of obstructive jaundice it is the lymphatic system of vessels alone which absorbs biliary matters, and it is wholly and solely through the instrumentality of the thoracic duct that the bile finds its way into the blood-vessels. 3. After the thoracic duct has been for some time ligatured an adventitious supplementary chyle duct forms by the coalescence of either newly developed or pre-existing collateral lymphatics from a point of the thoracic duct below the seat of ligature, through which its chyle and lymph are transmitted into the right innominate veins, and thus perform vicariously the transporting functions of the thoracic duct. 4. These facts, taken collectively, account, first, for the absence of bile acid and bile pigment from the urine in cases of obstructive jaundice, when the thoracic duct is ligatured. Secondly, for the reappearance of both the bile acid and the bile pigment, in spite of the closure of the thoracic duct, in the cases where dogs lived sufficiently long for the lymphatic anastomotic communication between the duct

and general circulation to develop. Thirdly, for the animals thriving so well after both bile and thoracic ducts had been ligatured, as well as conclusively showing that, as the blood capillaries had during the time these changes occurred been totally uninterfered with, they cannot be the agents of the absorption of the pent-up bile either from the hepatic bile-ducts or from the biliary appendages; while, on the other hand, they equally conclusively show that the absorption of bile is entirely dependent on the lymphatic system of vessels. 5. As bile is freely eliminated by the blood capillaries, though it is not absorbed by them, this proves that the endothelium of the blood capillaries has only the power of permitting bile to pass through it in one direction. 6. That after the common bile-duct is obstructed the constituents of the pent-up bile do not pass out of the bile tube and gall-bladder, to be absorbed by the lymphatics, in the same relative ratio; but, on the contrary, the mucin and cholesterin remain behind and become far more concentrated than either the lecithin, fat, soap, or taurocholate of soda. And this fact probably explains why cholesterin gall-stones are so much more commonly met with in the human subject than any of the other varieties. 7. That from the hepatic bile capillaries branch out fine bile canaliculi among the liver cells, some of which are seen to enter and to terminate in the interior of individual hepatic cells in blind extremities. 8. As the dogs experimented upon not only lived, but gained in weight, after bile was prevented finding access into their intestines, I am led to the opinion that under judicious feeding the presence of bile in the intestines is neither necessary to the digestion nor assimilation of certain alimentary matters, and consequently not indispensible to life. 9. That ligaturing of the thoracic duct in dogs not only prevents obstructive jaundice occurring after ligature of the common bile-duct, but that it actually checks the signs and symptoms of jaundice after they have appeared.

THE MAMMA.

In the *Lancet*, August 6, 1892, Dr. Williams, in a review of the development of the mamma, make these observations:

At birth the organ consists of from fifteen to twenty lobes, the excretory ducts of which are excavated and lined with a single layer of small cubical cells, the rest of the organ being still solid. "In newly born children," says Langer, "we rarely find anything more than the principal ducts, with some indications of ramification in the form of two or three club-shaped processes; and even if these be somewhat more developed, the terminal vesicles are always absent, even in those cases where fluid is secreted." This description has hitherto been generally accepted, but, according to De Sinéty, it is true only for stillborn children and for those who have died shortly after birth. He says that during the first ten days of extra-uterine life considerable formative changes take place in the gland, so that if it be examined at the end of this period some acinous tissue will usually be found resembling that of the adult female mamma during lactation and capable under certain conditions of secreting milk. These changes occur in both sexes and Variot describes them as attaining their maximum between the eighth and fifteenth days after birth. The male mammæ being functionally inactive continue in this imperfectly developed condition throughout life, although they generally manifest some temporary disturbance at puberty. In females remarkable structural changes set in at this period, but it is not until after conception that the organ attains its full development. Before puberty the female breast consists chiefly of excretory ducts, but as this period approaches the true secreting structure arises by the abundant new formation of glandular

acini. This wonderful post-embryonic transformation is brought about by progressive gemmation, in the same way as the initial embryonic development, of which it is but a superinduced repetition. This demonstrates that between embryonic and post-embryonic developmental processes there are no differences other than those of degree. In the words of Paget, "it is one and the same power which, being maintained continously from the germ to the latest period of life, determines all organic formation." The commencement of this mammary rejuvenescence usually precedes the first catamenial period, and at every subsequent period more or less temporary sympathetic reaction is excited. But the most important changes are those induced by the stimulus of conception, which converts the previously functionless structure into an active milk-secreting gland. During this period the acini attain their highest degree of structural perfection. This, however, is but a transitory condition which ceases after a time, when the stimulus is withdrawn, and is again renewed on its repetition. During the intervals between these periods the breast remains in a functionless resting state.

These and many other similar facts show that normal tissues may remain quiescent for long periods, and then suddenly take on new phases of growth and development.

INSOMNIA IN AN INFANT.

If there exists in the literature any record of real insomnia in very young infants, the fact has escaped my observation. The natural tendency of early infantile life is to spend itself mostly in sleep. The neurologically healthy babe during the first few weeks of its extra-uterine life is kept awake just as it is caused to cry by some unpleasant or disagreeable excitation. Much of the first six weeks of its existence out of the mother's womb is passed in sleep. A sleepless babe, not subjected to sufficient corporeal pain or irritation to provoke crying, is an anomaly. Yet such is the fact which I have to record of a female infant, five weeks of age, who, without physical or mental provocation, would lay awake with eyes wide open and gaze about in placid contentment throughout the night, unless sleep were induced, as in the more aged, by hypnotics. The child was quiet and tranquil and free from pain or other source of bodily discomfort.

It was well cared for by a faithful and intelligent nurse. Its napkins were always dry and soft, the umbilical cord had separated and the navel had healed, having been carefully dressed with simple cerate and patent lint; colic and constipation had been carefully guarded against. The babe nursed well, the mother had sufficient milk, and its environments were all favorable to rest and sleep, yet it slept not for several nights and not then until after receiving treatment for insomnia, as an adult would, only in proportion diminished to suit its age.

This insomnia would recur if the treatment were omitted, until about the end of the tenth week. The child then slept without medical assistance and became a vigorous and neurotically tranquil babe.

Sleep was only induced by five-grain doses of bromide of sodium and three-grain doses of chloral put into a small amount of milk and given the baby from a bottle. The chloral once at night and the sodium salt twice or thrice daily for a brief period. Celery and catnip teas and the hypophosphites were also given freely.

This child's mother had been much excited, mentally and nervously, verging on mental aberration, during the period of gestation and before, and required the skill of a practised alienist to avert a puerperal psychical climax after the birth of this infant. The mother was given hypnotics and the bromide salts quite freely during the first few weeks after the birth of the child, which may account

for the insomnia not having appeared earlier as an hereditary condition, as it appears really to have been. To my mind, the mother's neuropathic condition before and after birth and at the time of conception, explains the state of the child. Before the insomnia was arrested some slight chorea became manifest, but this disappeared with the restoration of normal sleep and neural recuperation and central nerve stability.—Dr. C. H. Hughes, in *Alienist and Neurologist*.

ON MISSED ABORTION.

Three typical cases of this condition are presented to his readers (*Lancet*, Aug. 6th) by Dr. Lewers, Obstetric Physician to the London Hospital. He says:

Cases of missed abortion are by no means uncommon; they are easily recognized if the possibility of the existence of the condition is kept in mind and proficiency has been acquired in the bimanual method of examination, especially so far as concerns the determination of the size of the uterus. Yet comparatively little prominence has been given to the subject by the majority of writers on gynæcology, with the notable exception of Dr. Matthews Duncan, whose classical lecture on "Missed Abortion" first led me to recognize cases of the kind. The history is usually of great importance. In most cases the patient, having been previously regular, misses one or more periods, and, especially if more than one period has been missed, most probably believes herself to be pregnant. If it should happen at this time that the medical attendant is called on to make an examination, the size of the uterus as determined by him may be of much value in making the diagnosis when other symptoms arise later on. We have, then, to begin with, an interval of amenorrhœa accompanied by the other symptoms and signs of early pregnancy. Generally the first indication of there being anything unusual in the case is the occurrence of hæmorrhage, usually at first slight and intermittent, the intervals between the losses being days or weeks; or it may be that there is a constant, blood-stained discharge, the proportion of blood varying from time to time. It is usually on account of this hæmorrhage that the patient seeks advice. It is obvious how valuable a previous examination of the patient may now prove, if a month or more has elapsed since the previous examination; for it may be found that the size of the uterus has remained stationary or has even somewhat diminished. It often happens, however, that we have no previous examination to guide us, and then it is best to compare the size of the uterus when the case is first seen with the size it should have been had the pregnancy been a normal one, reckoning from the beginning of the interval of amenorrhœa. The treatment depends on the amount or persistence of the hæmorrhage. In some cases bleeding is inconsiderable till pains come on leading to the spontaneous expulsion of the ovum; the first case recorded below is an example of this class. In other cases bleeding is often rather free from time to time, and may be continued over a long period without the uterus showing any tendency to discharge its contents. In the second case described bleeding had lasted three months. In such cases the right treatment is to dilate the cervix and clear out the uterus.

THE SYMPTOMS OF TUMOR OF THE PINEAL GLAND.

From an article by Dr. Philip Zenner, of Cincinnati, in the *Alienist and Neurologist*, for July, we extract the following summary:

Finally, I wish to give a brief summary of the nine cases previously reported. The ages so far as given were 39, 19, 50, 19, 28, 31, 32 and 25 years respectively, so that my own, 13 years of age, was much younger than any other reported. The tumors were described as sarcoma (2), glioma (2), carcinoma (2), psammoma (1) and cyst (1).

In five cases the headache was chiefly occipital, in two it was chiefly in the anterior part of the head.

In seven cases the intelligence was more or less impaired, if not altogether lost. In only one was it spoken of as normal.

In seven cases there was blindness or much impairment of vision. In three of these cases it is explicitly stated that the loss of vision was speedy.

Deafness was only mentioned in two cases, in one of which it was only in one ear.

Inability to stand or walk or difficulty in walking was mentioned in six cases.

Epileptic or tetanic spasms were reported in six cases. In one instance it was mentioned that there were no seizures of this character.

Difficulty in swallowing was reported only in Schulz's cases. Here it was said that the patient could not swallow with head erect. It was necessary to flex the head forcibly upon the chest, so that only fluids could be swallowed, and the latter were sucked through a glass tube.

Speech was spoken of as "slow" in Kny's case. Such disturbance is mentioned in only one other instance, the patient of Daly's.

Contractures, like those found in the left arm and feet of my patient, were not reported in any of the nine other cases. But in two cases the tendon reflexes were exaggerated.

In contrast with my own, in most of the nine cases there was some involvement of the external muscles of the eyes. In two instances the eyes were turned downwards and to the right without actual paralysis. In two others there was some protrusion of the eyeballs. In three there were nystagmus; in one ptosis. In several cases there were was either paresis or paralysis of the fourth, sixth or some branches of the third nerve.

It is impossible to say that there was no impairment of these nerves in my case. Paralysis of the fourth or paresis of the third or sixth nerves could not have been detected in the last six months of his life.

WHAT LIES BACK OF HER HYSTERIA?

In an article in the *Alienist and Neurologist*, for July, in which he endeavors to impress upon his readers the need of always asking himself this question, Dr. C. H Hughes, of St. Louis, says:

The conclusion, "Some hysteria, *ergo* all hysteria," is a clinical conclusion which has proven in numberless instances fatal to correct diagnosis and to the welfare of many patients.

This neurosis may be latent as any other inherent tendency to neuropathic instability may be said and often is, until some psychical or pathological cause calls it into morbid activity. While hysteria is essentially an irritative and functional disturbance of the psychomotor, sensory and ganglionic centers, it is no more unreasonable to expect its development in conjunction with grave organic lesions of the cord or brain than to anticipate pain or spasm from profound central disease or even from multiple neuritis of the motor nerves extending to the cord centers or involving contiguous peripheral nerve fibres.

The time has fully come in the progress of neural pathology and clinical neurology to recognize this fact and realize its true significance in our clinical judgments, for without such proper recognition we may be too often led astray in diagnosis and prognosis for our patient's welfare, or our professional reputations before a scrutinizing and discerning public.

Hysterical patients are prone to develop peculiar inherent neuropathic char-

acteristics of their organism under physical as well as psychical stress, and this physical strain may be a real central or peripheral structural disease.

It has been quite a number of years since the writer first began to think in this way and ample observation has confirmed the correctness of his earlier judgments, though not until after some serious clinical errors had been recognized after the issue had been determined *post-mortem*.

For a statement of the clinical cases, on which Dr. Hughes especially bases this advice, we must refer our readers to his original publication.

AMPUTATION IN DIABETICS.

At a recent meeting of the Royal Medical and Chirurgical Society (*Lancet*, June 18, 1892) Dr. W. G. Spencer read a paper on Amputation in Diabetes Mellitus. The author brought forward evidence to show that the timely adoption of amputation above the knee or elbow for the removal of severe inflammatory complications would prolong life, and very much reduce the amount of sugar excreted before operation. He urged that failures had resulted from amputating through the foot and leg when the vessels had been already narrowed or thrombosed, and that it was useless to attempt the reduction of the sugar by drugs and diet when severe inflammatory lesion was present. Cases were quoted to show that healing readily took place in diabetics, especially a malignant case of diabetes mellitus attacked with erysipelas and abscess, and which died in diabetic coma three weeks after healing. He then compared two cases: one of suppuration around the femur above the knee with no bone exposed, treated by palliative measures, ending in diabetic coma; the other of suppuration around the elbow with the lower third of the humerus bare, which recovered good general health after amputation through the arm. Urine before operation 1040, 10 gr. to 1 oz. of sugar; after operation 1023, sugar a constant trace. Drugs and diet influenced neither case, except in the latter after healing. Reference was made to other cases by Professor Roser, König, Kraske and Heidenhain. Professor Küster amputated through the thigh in eleven cases of diabetic gangrene: six recoveries—two primary, four after limited ulceration. Sugar before operation—(1) large, (2) 5 per cent., (3) 2 per cent., (4) 3 6 per cent., with one-third albumen (5) 1 per cent., (6) a trace. Five fatal; (1) In coma at operation; (2) double amputation of seven days' interval, (3), (4), (5) very albuminous urine. Stumps of fatal cases tending to heal without suppuration. Professor Küster's experience in senile and diabetic gangrene was quoted in support of the high amputation advocated by Mr. Hutchinson. Amputation four times of a toe—once through the foot by a Lisfranc, three times through the foot by a Chopart, six times through the leg. All became again gangrenous, and only recovered after secondary amputation through the thigh, except two legs in which the ulceration and necrosis were limited. Three cases of diabetic gangrene under Professor König and Mr. Langton recovered from amputation through the leg after ulceration and necrosis. Primary union had only been obtained after a high operation. Indications for operating in gangrene were mentioned, and cases illustrating the more favorable character of perforating ulcers, including one under Mr. Thomas Smith.

DIAGNOSIS OF DIABETIC COMA.

In the *International Medical Magazine*, for July, Dr. Henry, of Philadelphia, gives the differential diagnosis of this condition as follows:

Besides the odor just described, diabetic coma is often characterized by intense dyspnœa unaccompanied by any sign of pulmonary disease. This peculiar form

of dyspnœa is observed only in the early stages of the coma, before it has become profound, and may precede its onset. It is a purely nervous manifestation caused by the toxic action of acetone (?) upon the respiratory centre.

Another feature of diabetic coma is low temperature, the thermometer frequently registering 96° F. in the mouth or rectum, and having been observed as low as 86° F.

A most important sign of diabetic coma, though a negative one, is the absence of convulsions, which never occur in these cases, except in children.

Diabetic coma is to be distinguished from that due to alcohol, opium, and uræmic poisoning. In the first, the countenance is usually congested, and the temperature either normal or but slightly lowered; there is also no dyspnœa, and the urine is free from sugar.

Opium-poisoning is characterized by extreme contraction of the pupils and by slowness and irregularity of the respiration. The diagnosis between opium-poisoning and diabetic coma must, however, sometimes be held in reserve, on account of the fact that, in the former, glycosuria is occasionally present. A case of this sort is mentioned by De Gennes, in which the diagnosis of opium-poisoning was based upon the absence of the chloroform-like odor to which I have alluded.

Uræmic coma is very liable to be confounded with that of diabetes, loss of consciousness, a low temperature, and dyspnœa being common to both. Important points of distinction are the absence of convulsions in diabetic coma and the presence of the characteristic chloroform-like odor.

UNUSUAL ACTION OF ATROPINE AND HOMATROPINE ON INFANT'S EYES.

A number of interesting cases are reported by Dr. Carpenter, of London (*Lancet*, August 6). His comments upon them are as follows:

That children bear belladonna well and much better than adults is an established fact, and that they can absorb large doses of the drug without physiological reaction is sufficiently recognized. Like everything else, however, there is a *but* attached to the above statements, and as the result of my clinical observations that "but" is as follows: For some years now it has been my practice to make free use of the ophthalmoscope for diagnostic and other purposes. The combination of a pinpoint pupil, a roving eye, a screaming infant and a large out patient clinique not being conducive to rapid ophthalmoscopical examinations, I have been frequently compelled to make use of atropine or homatropine to facilitate matters. It is quite agreed that dilatation of the pupils is one of the most characteristic symptoms of belladonna. Ringer says that he has often given to children two or three years old as much as ten minims of the tincture every hour, and this quantity usually produces no effect, neither dilating the pupil nor making the throat dry. The only symptom he has ever noticed from these large doses is dilatation of the pupil. With these remarks I cordially agree.

As the result of my observations on young infants I find: 1. The pupil not infrequently in infants remains for a long time undilated, sometimes for hours. The reaction is often tardy, and the pupil may not dilate to its full extent. This is quite apart from iritis, iritic adhesions, or what not. 2. Physiological symptoms in infants not seldom occur: whether from absorption by the ocular conjunctiva or passage down the lacrymal duct and so on, I am not prepared to state—possibly both causes are in operation.

Exception may be taken to my first conclusion on the ground that the cases I quote were syphilitic; *ergo*, iritis or iritic adhesions were in action. My reply to that is: Putting aside the rarity of iritis in infantile congenital syphilitics in my experience, from systematic observation in a large number of such cases, they

presented neither iritis nor iritic adhesions to focal or ophthalmoscopical examination. Moreover, I think that assumption is quite out of court, for I have noticed it in others not syphilitic. As regards my second, a too liberal allowance of drops may be suggested. Putting aside the fact that the phenomena narrated soon supervened, they had no larger quantity—and possibly less from the difficulties attendant—than older children who show no such symptoms. The atropine drops contained one per cent., or four grains to the ounce: the homatropine drops also contained one per cent., or four grains to the ounce.

THE CHOREA OF PREGNANCY.

In an article upon this subject (*International Medical Magazine*, July, 1892), Dr. Lloyd, of Philadelphia, gives the prognosis as follows: Very practical questions are involved in the prognosis both to the mother and the child. Some years ago an English obstetrician, Barnes, wrote a paper on all the cases of the chorea of pregnancy that he could find in medical literature. His statistics seem to prove that about seventeen out of fifty-six are fatal. I think that this is an over-estimate, for this reason. It has happened in the past that only the fatal or the severe cases have been reported. I have seen five cases of the chorea of pregnancy, none of which have been fatal. Milder cases are not apt to get into print. I think that, while the chorea of pregnancy is a grave disease, it is not as grave as Barnes's statistics seem to prove. Another question comes up—the prognosis in the case of the child. Statistics have also proved that some of these women go into premature labor, and that some of these children are still-born or die shortly after birth, probably because of the premature labor or because of the mother's reduced condition. A very practical question which you will have to face is, whether or not you shall bring on premature labor or even abortion. Many of these cases of chorea in pregnancy certainly recover after labor, but a small proportion do not, and on that account it is difficult to advise when premature labor should be induced. When the woman's life and the babe's life are in jeopardy it is justifiable, even imperative, to act. I think that after seven months, in some few cases, the chances for the babe's life may be better if taken from the mother. Recollect, however, that women do not all recover after confinement, and that the child sometimes does not live.

VARIABILITY OF DISEASE-GERMS.

At the recent meeting of the British Medical Association, Dr. Adami, of Cambridge, contributed a paper upon the Variability of the Bacteria. He pointed out that while it was generally held that the species of bacteria are definitely fixed, possessing properties that are constant, year by year more investigators are recording facts not in harmony with this view. The subject is one of such great importance that he had repeated a large number of the observations made by Schottelius, Laurent, Gessard, Charrin, Wasserzug and others upon the variability of chromogenic bacteria, etc., and had determined their correctness. He demonstrated variations occurring in the bacillus pyocyaneus, B. ruber (Kiel), B. ruber (Plymouth), microbacillus prodigiosus, M. indicus, sarcina erythromyxa and torula rubra, and showed that the amount of modification impressed upon the microbe and the durability of the same depend upon the extent to which the media of growth, temperature, etc., are modified.

SELF-MUTILATIONS BY GENERAL PARALYTICS.

Accusations, mostly false, brought against attendants, of ill-treatment of patients affected with that too common variety of mental alienation, general paralysis of the insane, are familiar to every practitioner. It is, therefore, a matter of

importance to be fully aware of the injuries which such patients are wont to inflict upon themselves. M. Vallon observes (Société de Mèdicine Légale, 11th inst.) that certain general paralytics are in a constant state of agitation, their upper and lower extremeties never being still. Others occupy their whole time alternately buttoning and unbuttoning their clothes, dressing and undressing, while others, again, tear their clothing or the sheets. These latter patients may, especially when totally confined to their beds, inflict upon themselves more or less extensive injuries without the attendants knowing anything about it.

M Vallon gives a few instances of such mutilation produced by constantly recurring movements of limited range. One sufferer had a long deep wound of the thigh caused by the nails of the right hand in its incessant to-and-fro movements. In another the testes had been similarly laid bare, while yet another had lost part of the nose through the same mechanism. Constant grinding of the teeth is common in this class of patients, entailing the ultimate wearing down of those masticatory instruments. A habit of continually sucking either *à cide* or the sheets or pillows is also met with. One of M. Valion's patients was suffocated by a poultice, originally applied to a wound, the defunct paralytic sucking it almost in its entirety. Another curious case is that of a man in whom enormous swelling, followed by gangrene of the lower lip, had resulted from this constant sucking. These few examples suffice to emphasize the necessity of closely watching general paralytics who, arrived at the terminal stage of their disease, may, during the long hours of the day and especially the night, succeed in damaging themselves very seriously.—Paris correspondence of *Lancet*.

RADICAL CURE OF URETHRAL STRICTURE.

Dr. Bruce Clarke closes an article upon this topic in the *Lancet*, July 16, with these words:

It has been long recognized and it is now pretty generally admitted that penile strictures demand incision, whilst those more deeply situated are quite amenable to dilatation. It is certainly a curious fact that anterior strictures will not often yield to dilatation, and this is probably due to two facts: 1. The septum pectiniform of the penis is unusually firm and unyielding at its anterior portion; 2, the causes—such as syphilitic sores and very acute inflammations, usually of gonorrhœal origin, which tend to produce anterior strictures, are usually attended with a great deal of inflammation, and thus give rise to strictures of a very unyielding nature. Still the anterior strictures are interesting in other ways. Some of those which are situated within the first inch of the urethra are certainly capable of real cure. In the first place, they are visible to the eye, so there can be no dispute about their existence; in the second, they can be kept in view whilst they are being divided; and in the third place, they can be kept dilated with very large instruments for any period that may be considered to be necessary. If cure be desired in such cases the stricture should be kept dilated for a few minutes daily with a short conical steel bougie for at least six months, after which time the dilatation should be carried on once or twice a week for four or five months more, at the end of which time there will be found to be in most cases (probably in all) but little tendency to recontraction. Surely if such a result can be obtained with such severe strictures, it should encourage us to hope for cure in those more deeply placed.

With regard to the strictures which are more deeply situated there will probably be much difference of opinion as to how they should best be handled. Many of the slighter ones are so readily amenable to occasional dilatation that few pa-

tients are disposed to submit to more prolonged treatment. With the more severe types whenever there is much thickening to be felt from the outside, if there is tendency to congestion, as is shown by their readiness to bleed, or by their admitting instruments of variable size within a short period, no plan has yielded in my hands such good results as electrolysis. I have on more than one occasion published an account of cases with their results several years afterwards, and further experience leads me to assert confidently that in suitable cases excellent results will with care be obtained.

If I were asked to formulate in a few words the most essential points in the treatment of stricture of the urethra I should be inclined to say: 1. Make certain you have a true stricture to deal with. 2. Take the greatest care to keep it dilated for a long time after it has been incised. 3. Where there is much thickening employ electrolysis.

THE ÆTIOLOGY OF TYPHUS.

Thoinot (*Boston Medical and Surgical Journal*) says:

Typhus is, in all probability, the function of a figured germ, whether that described by Hlava, the one studied by myself, or some other micro-organism.

Typhus is endemic in certain countries, nor do we know the reasons of this endemicity—whether or not it may be due to the cultivation of the germ in the soil, to the qualities of the races which perpetuate the existence of the germs by slow and successive transmissions, etc. We are very ignorant on these points.

Typhus becomes epidemic in certain cases and spreads far from its starting-place, or invades dense agglomerations of people. The adjuvant conditions of the diffusion are overcrowding the general condition and physiological depravement (*misère physiologique*)—a personal condition, which may, moreover, be generalized in a collection of individuals, as in cases of tribal or national destitution and of famine.

Typhus does not always leave behind a focus of endemicity when it invades an army or a country epidemically, in this respect resembling cholera.

The transmission of typhus is effected by direct contact with the patient, or by contact with objects which are charged with the specific germ from intimate contact with the patient.

The channels of inoculation of the disease, as also the channels by which the germ is expelled from the sick organism, are unknown to us. It is probable that the products of cutaneous excretion play a principal rôle.

The air does not appear to be a vehicle of contagion, and the same may be said of water.

USE OF NITRATE OF SILVER IN URETHRAL INFLAMMATIONS.

Dr. R. Guiteras (*Journal of Cutaneous and Venereal Diseases*) says:

Nitrate of silver is not as dangerous in acute urethral inflammations as is generally supposed.

By beginning with small doses and increasing daily a tolerance can be established (the same as in chronic cases).

Although a solution of the strength of 15 or 20 grains to the ounce can be reached in this way, it is not wise to go above 8 or 10 grains; and then if the result is not favorable to continue with some other means.

In this, as in bichloride irrigations, and all other methods which try to cure this trouble quickly, a dry, congested and slightly irritated condition is liable to follow, which should be treated for some days by mild astringents, these to be left off gradually.

When the discharge becomes very slight, it is better at times to decrease the strength of the arg. nit. than to increase it.

In cases of gonorrhœal cystitis, which are usually acute, good results are obtained by instillations of this drug.

In cases of chronic deep urethral inflammations, especially those of a granular nature, deep urethral injections are the remedy *par excellence*.

Nitrate of silver as an abortive should not be used, as in doing this perinurethral inflammations may be set up, which might cause considerable trouble.

Medical Items.

Professor Rudolf Virchow was elected Rector of the University of Berlin on Wednesday evening, August 3rd.

The *Chicago Medical Recorder*, edited by Dr. Archibald Church, and previously published by W. T. Keener, of Chicago, is now being published by that well-known house, the M. H. Kauffmann Medical Publishing Company.

The citizens of Hagerstown are petitioning the town council for the appointment of a Health Officer. It is to be hoped that a capable physician will be quickly installed in that responsible office.

Cumberland is greatly exercised concerning the improvement of its water supply. The question has arisen, whether the increase should be taken from the Potomac, as at present, or whether spring water shall be used.

We learn from the daily papers that the enterprising town of Delmar just across our border in Delaware was nearly destroyed by fire on Tuesday. Of the 800 inhabitants, 300 are homeless. As far as known no lives were lost. While sympathizing deeply with the townsmen, we look to see the town rise quickly from its ashes, full of new vigor and beauty.

Assafœtida has been recently recommended in cases of habitual abortion. Dr. Turazzo gives it in pills containing a grain and a half as soon as it becomes clear that a new pregnancy has commenced. At first only two pills are prescribed but later on the number is increased gradually to ten daily. That treatment continued until the labor is over, and then the daily dose is gradually diminished. By this method cases where as many as five successive abortions had occurred have been successfully treated, and where in one instance a miscarriage appeared to be imminent during the seventh month it was averted and the patient was delivered at full term.—*Lancet*.

The following are the flags in our army in accordance with the requirements of the international convention on the work of the Red Cross Society. For general hospitals, white bunting, 9 by 5 feet, with a cross of red bunting 4 feet high and 4 feet wide in the centre; arms of the cross to be 16 inches wide. For post and field hospitals, white bunting, 6 by 4 feet, with red cross of bunting 3 feet high and 3 feet wide in the centre; arms of the cross to be 12 inches wide. For ambulances, and guidons to mark the way to the field hospitals, white bunting, 16 by 28 inches, with a cross of red bunting 12 inches high and 12 inches wide in the centre; arms of cross to be 4 inches wide. A brassara of white cloth 16 inches by 3 inches, on which is a red cross 2 inches by 2 inches, to be worn on the cuff of the left arm.—*Columbus Medical Journal*.

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CONTENTS

ORIGINAL ARTICLES.

Report of Case of Asphyxia by Illuminating Gas. By James T. Johnson, M. D., Baltimore. . 947

El Paso, Texas, as a Winter Health Resort. By Aluard White, M. D. 949

EDITORIAL.

The Medical Anarchist and Ethics. . . 952

Water *versus* Ice as a Disease-Producer. . 952

An Improvement. 953

REVIEWS, BOOKS AND PAMPHLETS. . . . 954

MEDICAL PROGRESS.

Legislation in New York for the Systematic Treatment of Epilepties.—Hypnotism.—Treatment of Delirium Tremens.—Diagnostic and Prognostic Value of Tendon Reflexes.—The Evolutionary Significance of Decay and Death.—Eczema in Infants and Young Children.—On the Functions of the Tonsils.—Sterility.—Examination of the Blood for Gonococci.—A Case of Cocainism.—The Treatment of Diarrhœa by Salol.—Double Ovariotomy. . . . 955

THERAPEUTIC RECOMMENDATIONS. . . . 967

MEDICAL ITEMS. 946

Original Articles.

REPORT OF CASE OF ASPHYXIA BY ILLUMINATING GAS.

BY JAMES T. JOHNSON, M. D.,

Resident Physician, Maryland General Hospital.

Patrick T., white male, age 32, was admitted to the Maryland General Hospital, medical service of Professor David Streett, at 9.30 A. M., April 22nd, 1892.

One hour previous to admission, he had been discovered, comatose, in his room, a small attic, with windows and door tightly closed. The room was full of gas, which was still escaping from the jet, just as he had left it, when at three o'clock in the morning he had returned to his room, and, as he subsequently stated, being half intoxicated, blew out the gas.

Patient on admission was unconscious, pulse 80 per minute, soft and weak, respirations shallow, 5 per minute, extremities, ears, nose and lips cold, pinched and blue. Deglutition impossible, rectal sphincter paralyzed, feces passing involuntarily, bladder distended with a large quantity of retained urine.

Trinitrin and whiskey hypodermatically were employed at once and repeated at intervals, the immediate result being a notable improvement of cardiac action. Artificial respiration, after the method of Sylvester, was steadily employed for five hours. During this entire period, whenever the patient was left to voluntary effort, artificial respiration being discontinued, after a few feeble at-

tempts breathing would cease, the cold douche and slapping chest with cloths wrung out of ice water provoking only a few feeble gasps.

To stimulate respiratory effort strychnia sulphate in $\frac{1}{60}$ grain doses was administered hypodermatically, some improvement being noted after each dose; but not until the third dose had been given, five hours after entrance into the hospital, did patient's breathing improve so much that it was deemed safe to discontinue artificial respiration. At this time respirations, though rather irregular, were averaging 10 per minute.

Twelve hours after entrance into the hospital, patient began to develop some pyrexia, his temperature at no time exceeding 100°F. The elevation of temperature continued for twelve hours; there was also active delirium, which was partially controlled by ice bag to head and chloral hydrate internally. The delirium was marked by great restlessness, the patient tossing heavily from side to side of the bed, seeming to gasp for breath, then after a few minutes settling quietly down with a long-drawn sigh, and breathing quietly as an infant; then, after resting for a short interval, the jactitation was repeated as before.

On the second day respirations remained at eleven per minute, temperature fell to normal, patient took liquid nourishment and rested well. Catheterization still necessary: strychnia sulphate and whiskey continued.

On the evening of the third day, though there was yet extreme depression, patient was comfortable, respirations 18 per minute and urination and defecation under voluntary control. On the fifth day, patient was so far recovered as to be removed to his home.

Daily urinalyses were made. For forty-eight hours after admission the urine was loaded with albumin; the volumetric per centum was not determined.

From this time there was a rapid daily decrease in the amount of albumin, until on the day of discharge there remained only a trace in the urine. An analysis of the urine one week later revealed the total disappearance of albumin. Microscopic examination of the urinary sediments showed only a few hyaline casts.

Attentive observation of the immediate effects of the drugs used leads to the conclusion that strychnia was the drug to the use of which the successful issue of the case was largely due, in addition, of course, to supplementing voluntary by artificial respiration. Almost at once following each hypodermic of strychnia both the depth and frequency of inspirations was notably augmented. Death seemed imminent from deficient respiratory effort, cardiac action remaining relatively good. Trinitrin, alcohol and ammonia, though immediately and certainly stimulating the heart, did not seem similarly stimulant to the respirations, while strychnia satisfactorily fulfilled this indication.

The remarkable feature of the case is the survival, by the patient, of five hours in a small tightly-closed room, the atmosphere of which was saturated with gas, and his final recovery after five hours of artificial respiration had been necessary. In the ordinary run of coal-gas asphyxias, after a similar or often far shorter period

of exposure, the blood has already reached that condition that as an oxygen carrier it is inadequate to the needs of the individual. Owing to the stable combination of carbon mon-oxide with the hæmoglobin of the blood, forming carboxy-hæmoglobin, which is not an oxygen carrier, death results from suffocation, even though plenty of oxygen is supplied to the lungs.

The practical bearing of the case lies in the illustration of the value of strychnia in poisoning by carbon mon-oxide. Its well-known physiological effect of stimulating the respiratory function accomplishes increased oxygenation of the intact hæmoglobin by the increased respiratory effort.

EL PASO, TEXAS, AS A WINTER HEALTH RESORT.

BY ALUARD WHITE, M. D.

With the approach of winter there is scarcely a physician "east of the Mississippi" who will not be confronted with the annually recurring question, "Where shall I advise my patients suffering with chronic pulmonary troubles to spend the ensuing six months of the year, in order to escape the inclemencies of the weather?" The difficulty lies, not in getting an answer to the question, but in determining which of the many much-vaunted places of resort is best suited to the needs of the invalid. Theoretically the most satisfactory answers should come from the qualified practitioners residing at the various places of resort, but such is the diversity of opinion, and so very wide apart are the afore-mentioned observers (as wide as is the distance between the coast of Florida and Pike's Peak, in Colorado) that one is naturally led to be a little distrustful of their statements; to feel that there lurks in the glowing pictures which they draw at least a suspicion of self-interest. Thus we are told of results equally good attained at Aiken, S. C., and Manitou, Colorado, places as wide apart in point of climatic conditions as they are in actual distance. Hence it would seem that the safest way for one to determine the question would be to ascertain first, in a given case, the climatic conditions that prevail at the different places of resort, ascertain which is best suited to the individual in question. For guidance in the matter of selection one cannot go far wrong in accepting the conclusions of C. J. B. and C. Theodore Williams, who state: "*High altitude stations* are most beneficial for cases of: 1st, marked hereditary predisposition, in which phthisis is either threatened or in a state of early development; 2, imperfect thoracic, or pulmonary development; 3, hæmorrhagic phthisis; 4, chronic pneumonia (without bronchiectasis) which does not resolve; 5, chronic pleurisy where the lung does not expand after the removal or absorption of the fluid; 6, phthisis accompanied by more or less pneumonic consolidation; 7, chronic tubercular phthisis in its various stages, provided the lung surface be not too largely involved to admit of proper respiratory change at the high altitude, and there be no pyrexia. On the other hand, mountain climates are contra-indicated in cases of: 1st, emphysema, and phthisis with emphysema; 2, chronic bronchitis and bronchiectasis; 3, diseases of the heart and great vessels; 4, affections of the

brain and spinal cord and states of hypersensibility of nervous system: 5, diseases of the kidneys; 6, diabetes; 7, pyrexia; 8, phthisis with double cavities, with or without pyrexia; 9, all cases of phthisis, in which the pulmonary area is too largely encroached upon to admit of the proper performance of the respiratory function; 10, cavity cases, with profuse hæmoptysis, pointing to the probable existence of pulmonary aneurism; 11, cases of phthisis with great irritability of the nervous system; and 12, patients advanced in years, or too feeble to take exercise."

The cases best suited for sea voyages are: 1, hæmorrhagic phthisis; 2, scofulous phthisis, especially when fistula has developed; 3, cases of limited consolidation or cavity where, without pyrexia, the cough is hard and obstinate, probably from bronchial involvement; 4, cases of phthisis with emphysema; and 5, cases of limited tuberculous disease in patients who have been over-worked in mind and body. Bearing the foregoing in mind, it but remains to obtain accurate information regarding the climatic conditions that prevail at the different places of resort, in order to fit the subject to the locality. The purpose of this article is simply to furnish such data regarding El Paso, Texas, and the vicinity. As a glance at the map will show, the town is situated nearly midway on the continent, at the western extremity of Texas, about equi-distant from the great cities of Mexico, St. Louis, New Orleans, Kansas City and San Francisco, and has direct railroad communication with them all.

The city is eligibly situated on an elevated plateau, on the left bank of the Rio Grande river; from a sanitary standpoint the site is all that could be desired, the land has natural trend toward the river, and is consequently self-draining; in addition there has been constructed, and is in successful operation, a complete system of sewage. The soil is a porous, non-retentive sandy loam. The streets and sidewalks are well paved, and thoroughly policed. The buildings, both for business and residence purposes, are substantial and attractive in appearance. The population, about 11,000, is mostly American, and is largely composed of enterprising, educated and intelligent people. The town is possessed of all the advantages that accrue from the possession of good schools, churches, representing nearly every denomination, street railways, a good telephone service, good hotels, a fine opera house, a race course, etc. Thirty-seven hundred feet above the sea, on the 32nd parallel of north latitude, and the 106° of longitude, west, it is possessed of all climatic advantages which naturally pertain to the "elevated mountain regions," *i. e.*, a dry, rarefied, aseptic atmosphere; lessened barometric pressure, a small relative atmospheric humidity, a very small annual rain-fall, and as little diurnal fluctuation of temperature as is compatible with the other conditions existing. The following table showing mean barometric pressure, mean temperature, dew point, relative humidity and rain-fall for the past three years, is taken from the report of the chief of the Signal Service Bureau, and shows not only the conditions that prevail here for the months enumerated, *i. e.*, from October to May, but demonstrates also when compared with reports from all

other stations in the United States, that there is no other place of resort at all eligibly situated, that has as many days of sunshine, as small a rain-fall, as little relative humidity, or such slight fluctuations of temperature.

Month and Year.	Mean Barometric Pressure.	Mean Temperature.	Dew Point.	Relative Humidity.	Rain-fall.
1888.					
January	26	46.	22	42	.03
February	26	50.2	30	49	0.15
March	26	59.1	33	41	0.32
April	26	63.	28	30	.09
October	26	63.4	49	62	0.78
November	26	54.2	39	59	0.51
December	26	40.2	28	64	1.01
1889.					
January	26	44.8	29	55	0.32
February	26	50.1	36	62	1.51
March	26	54.6	34	48	0.95
April	26	66.9	40	42	0.74
October	26	62.8	42	54	1.13
November	26	51.	34	58	1.32
December	26	44.1	29	58	.05
1890.					
January	26	41.	24	42	0.76
February	26	47.	17	23	0.18
March	26	53.	24	28	0.69
April	26	67.	23	14	.04
October	26	65.	36	28	0.35
November	26	49.	23	30	0.55
December	26	53.	27	28	0.00

Exempt for the months enumerated, alike from extremes of both heat and cold, it as nearly fulfils the idea of a perfect climate for the class of invalids to which the altitude treatment is adapted, as can be found on this continent; and while there are no available statistics by which to show the percentage of cures as compared with other places of resort, it is noteworthy that during the winter months invalids come here in scores from such noted places as Denver and Colorado Springs to escape the ill effects of the extreme cold, where, if statistics are to be relied upon, the largest percentage of cures are obtained.

ABORTIVE TREATMENT OF ERYSIPELAS.

Talamon (*Münchener medicin. Wochenschrift*, 1892, No. 28, p. 501) recommends the employment of a spray of sublimated ether (1 : 100) in the treatment of some cases of erysipelas. If the infiltration be not extensive, the application is to be continued until vesication occurs; if the involvement be extensive, the central portion is only to be moistened; as the periphery is reached, the application is to be more vigorous and should extend beyond the line of demarcation. But few applications are necessary. If the eyelids are involved, they should be covered with moist borated compresses.

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BALTIMORE, AUGUST 27, 1892.

Editorial.

THE MEDICAL ANARCHIST AND ETHICS.

It was Marx, we believe, who first put into speech the aspiration of the political anarchists, as "No God, no king, no policeman." The cry of the medical anarchist is like unto it—"No ethics, no code, no restrictions." If anarchy ever secures a majority in any country not only will society be overturned, but the formation of societies, such as the American Medical Association, will be frowned upon, and in the end be rendered impossible.

According to the medical anarchist the subject of medical ethics should never be brought up at all in medical societies. "It crowds out," he says, "improving clinical topics, and leads to disputings and dissentions among the members."

It has been said that discussions upon ethics are peculiarly acrimonious. In our experience this is not true; it depends upon the disputants, and not upon their subject, whether bitterness is displayed or a gentlemanly considerateness.

According to our experience it is the temperament (perhaps his temper also) of the orator that tells the story. Sometimes it is dyspepsia that speaks. Sometimes the temperature of the rostrum, sometimes the dietetic regimen, repeat themselves in the highly seasoned quality of the debate; but generally speaking it is not so much any of these as it is an undisciplined self-love that tends to make the meeting over-lively. And that self-love is liable to obtrude itself in every debate, irrespective of the subject before the house. The cultured *gentleman* in any heated discusssion generally serves the purpose of an antipyretic.

WATER *VERSUS* ICE AS A DISEASE-PRODUCER.

In the extremely hot weather through which we have passed this summer the number of cases of persistent subacute indigestion has been quite worthy of attention. It seems evident that, however great the influence of the weather may be as a predisposing cause, the exciting cause is in the food or drink. As the

food is mostly cooked we need not look for it there: and the melons, etc., are certainly wholesome, even if uncooked. As far as we have been able to observe, the milk furnished our patients has been good and wholesome, if bought from one of the best dairies.

By some writers it has been alleged that ice is a great carrier of disease. The ice supplied in this city, cut from northern rivers, appears to be very pure. The patients referred to seem to get great benefit from eating it crushed. It is, in fact, about the only thing which allays the continual thirst, as milk is the only food which agrees.

In regard to the city drinking-water we have very grave doubts. We believe that it is the cause of the indigestion in many cases. The fact that a city chemist *"has analysed it and found it wholesome,"* does not influence us at all in forming our conclusions. The Gunpowder water is probably reasonably pure, but the Lake Roland supply certainly is not. The lake is a basin lined with decomposing vegetable matters and receiving the drainage of many stables and houses in the country about it. As there is no other outlet for such drainage, and as no effort is on foot to clean the bottom of the lake, these impurities will be likely to remain in the water in spite of injunctions against residents and analyses for ammonia. If the city drinking-cup is known to be dirty, there are better ways of proceeding than by analysing the water in it. We have long been aware, however, that our health authorities are unable to see dirt in its gross form, as long as there is some microscopic germ to which they can direct their attention.

Under the circumstances it is likely that the summer mud inundations, and the presence of decomposing organic matters (as of the microscopic sponge found by Professor Remsen) will continue to distinguish our water supply. The best thing the citizen can do is to *boil* the drinking-water, both before and after the city analyst has found it wholesome. By actual test of drinking it, the water thus boiled is found to be comparatively wholesome.

AN IMPROVEMENT.

We take pleasure in pointing out to our subscribers the much neater appearance of the "original article" columns, which have appeared since last week. It is the desire of the proprietor of the journal to add gradually to the attractiveness of its pages by such changes as may seem expedient. With the improvement referred to, the objection to the single wide column is greatly lessened.

The editor will endeavor throughout the summer and autumn to keep the editorial and "progress" columns up to the mark. The fullness of the "original article" department must be left largely to subscribers. The editor cannot be expected to write all the original articles himself, and must appeal to the medical thinkers and clinicians of the State to do their part *promptly* and *fully*.

Next to Maryland, we desire articles from the South, which is the natural

field for circulation of Baltimore journals. Some day it will become apparent to Baltimore physicians that it is to their interest to support *with enthusiasm* their *own* medical journal, which is without dispute the leading weekly of the South.

Reviews, Books and Pamphlets.

Book on The Physician Himself and Things that Concern His Reputation and Success. By D. W. CATHELL, M. D. Tenth edition, carefuly revised and greatly enlarged. 8 vo., cloth, pp. 343. The F. A. Davis Co., publishers, Philadelphia and London, 1892. Price, $2.

The appearance of the tenth edition of this remarkable work recalls with satisfaction the favorable notice with which the MARYLAND MEDICAL JOURNAL reviewed the first edition some twelve or more years ago. There were many of our professional associates who did not share in our favorable opinions, and in the predictions of success which we then made. There are few now, we imagine, who would question the usefulness of the book, and none can question its remarkable business success. All must confess that Dr. Cathell struck the profession's weak point. Hitherto the only ambition of many of our best physicians was to excel in acquiring professional skill and knowledge, and the young were trained in this view. Business matters were considered *infra dig*, and it was with something of an apology that the doctor summed up resolution to send out bills or ask a delinquent patient for the payment of hard-earned fees. We may thank "The Physician Himself" for doing a great deal to correct this error and teaching us that the business side of our work is as honorable and quite as necessary as the scientific and humanitarian side.

In this the "author's last version" much new material has been added, without additional cost, however, and the precepts laid down are impressed upon the mind by brief but apt quotations scattered thoughout the text. The same straight-forward style, business sagacity and high moral tone pervade this as former editions.

In its present and lasting form the work will doubtless continue, and in a degree larger than ever, to be the young physician's *vade mecum*, quite as essential to his outfit as his Thomas, Flint or Gray.

The edition is gotten up in the same style of typographical excellence as its predecessors, and we again congratulate the author on his well-deserved success, and on the good which he has been the means of accomplishing in his profession.

Electricity in Carcinoma. By ROBERT NEWMAN, M. D., of New York. Reprinted from *Times and Register*, October 16, 1891.

Fifth and Sixth Annual Reports of the Pennsylvania State Board of Health, December, 1889, and December, 1890. Harrisburg: Edwin K. Meyers, State Printer.

Thirty-Sixty Annual Announcement of the Kentucky School of Medicine of Louisville, a spring and summer school, session of 1892.

Seventh Biennial (22nd and 23rd Annual) Report of Maryland School for Deaf and Dumb, 1889 to 1891. Frederick, Md., printed at the school, 1891.

Applications on behalf of colored deaf-mutes should be made to superintendent, 649 W. Saratoga St., Baltimore.

D. Hayes Agnew, M. D., LL.D.; A Biographical Sketch by his pupil, friend and assistant, De Forest Willard, M. D., read by invitation before the Philadelphia County Medical Society, April 13, 1892.

Reports from the Consuls of the United States, No. 141, June, 1892. Washington: Government Printing Office.

Enlarged Tonsils and their Harmful Effects on Health and Development. By Wm. T. Cathell, M. D., of Baltimore. Reprint from *Medical and Chirurgical Faculty Transactions,* 1891.

The Wills Eye Hospital, South Logan Square, Philadelphia, founded April 2, 1832. Report for 1891. Philadelphia, 1892.

Bureau of the American Republics, Washington, D. C. Columbia Bulletin No. 33, January, 1892.

Medical Progress.

LEGISLATION IN NEW YORK FOR THE SYSTEMATIC TREATMENT OF EPILEPTICS.

A bill, passed in 1892, directs the Commissioners of the State Board of Charities of New York to select a site for an institution for the care, treatment, employment and education of epileptics, and to report their selection with plans for buildings to the next Legislature. It is distinctly provided that the colony plan shall be adopted in the establishment of this institution. There are no limitations as to site. This legislation is the result of an active campaign begun two years ago by the Association. The reports of our visitors and of the Secretaries showed that there was a considerable number of persons in the poorhouses of all all ages suffering from epilepsy, and yet without proper care or treatment, and without employment or training. The Hospital Committee was directed by the Board under a resolution of April, 1890, to make a special inquiry into the conditions of this class, and to study the best methods of care and treatment in vogue in other countries and States. A sub-committee was appointed, consisting of Dr. Emily Blackwell, Chairman of the Hospital Committee, Miss Louisa Lee Schuyler, Dr. George W. Jacoby, Dr. Frederic Peterson and the Secretary. A report was submitted in January, 1891, and printed in full in the *Medical Record* for February of 1891. As a result of this report and upon its recommendation, a bill was introduced in the session of the Legislature of 1891, but failed of passage because of the deadlock which ensued in the Senate. It should be stated that Dr. Peterson, who has made for years a special study of epilepsy, had caused to be introduced a bill for which the Association's bill was with his consent substituted. The same bill, with modification as to the constitution of the Commission and the amount of appropriation, was introduced at the session of 1892. It received the support of the President of the State Board of Charities, the State Commission in Lunacy, the Superintendents of the Poor, Superintendents of the State Institutions for the insane and feeble-minded, physicians and almost the entire press of the State.

HYPNOTISM.

Dr. James Cumming, in the *Lancet*, speaks of hypnotism as follows:

Hypnotism and its allied states have long exercised a powerful fascination on a large portion of the intelligent public, and been looked on with much curiosity, but always with a little suspicion by physicians. Although not new, these singu-

lar and striking manifestations have of late been more carefully studied, the methods of producing them have been more clearly ascertained, and one is glad to notice that, instead of being relegated to non-professional men, they have engaged the attention of some of the physicians most competent to conduct such inquiries and most capable of estimating their results with precision and judgment. Whatever verdict may ultimately be passed on hypnotism there can be no reasonable doubt that certain facts have been elicited which show that in the hypnotic condition profound and extensive modifications occur in the sensory and motor functions of the brain.

Now, admitting that much has been urged against hypnotism; granting that it is likely to attract the attention of the men who have a liking for the marvelous; that it can be practised by men possessed of no scientific training, and incompetent to deal with the most refined activities of the nervous system, and that it thus lends itself to charlatanism and imposture; granting that it may be attended with danger of a formidable kind, and also that its field of therapeutic usefulness is likely to be at best a very restricted one, and its effects probably transitory; still it is a subject eminently deserving the careful and profound scientific investigation, conducted under the most rigid precautions, so as to exclude intentional or involuntary deception. We do not need to be much concerned about whether, as has been stated, we have in hypnotism a condition akin to natural sleep, or whether it is in reality a pathological state related to hysteria. What is now wanted is a clear account of the phenomena which are capable of being produced under its influence. If, as numerous statements aver, hypnotic suggestion can be shown to in any degree affect processes of nutrition and the reaction to irritants, then some points of the very highest interest as regards the influence of psychical on physical processes will have been established. Most of us have been inclined to read with a considerable degree of skepticism the accounts of instances in which obvious physical changes have been stated to have resulted from nervous influence, especially when these changes have occurred in a rapid manner. Should the statements on this subject which have been made so positively, and on the faith of apparently cautious and trustworthy observers, prove to be authentic, we shall certainly be compelled to reconsider our position with reference to them.

The opinion is generally entertained that the diseases of the nervous system are now more widely diffused and more numerous than formerly. It is somewhat difficult to obtain accurate statistics on this question and not altogether easy to ascertain their precise value, but some facts seem open to no serious question. In Ireland the proportion of the insane to the population has steadily increased. Even allowing for the fact that emigration takes away in the main the healthy and strong, and that consequently this represents the proportion of insane to a much larger population than now exists in the country, still it indicates a very notable increase. The reports of the Registrar-General for England show an almost uninterrupted increase in the mortality from nervous diseases. Some of this is no doubt explicable in other ways, but on the whole the evidence of statistics coincides with the general opinion among physicians that there is an augmentation. Whether this depends on the increase of causes tending to overwork and weary and exhaust the brain and nervous system we need not at present stop to discuss. Now, even those of us who have no special connection with the treatment of the insane find ourselves frequently brought into contact with questions regarding insanity. Apart from the mere granting of certificates, which, however, is attended with much anxiety and with heavy legal responsibility, there

are the numerous minor forms of aberration in which it hardly becomes a practical question whether they necessitate restraint or not, and there are also the many instances in which general affections produce mental phenomena. Then we have the numerous cases of temporary insanity which are never known beyond the families of the sufferers and the medical men to whom their care is entrusted, as well as the incipient stages of mental disease in which skilful management is of the utmost importance.

Now, the study of medical psychology alone is to my mind a very incomplete and inadequate preparation for comprehending the multiform disturbances of mental function and is even more inadequate in respect of either diagnosis or therapeutics, and in regard to the expectation of adding to our knowledge of cerebral diseases as regards either localization or character. I have long been of opinion that some knowledge of psychology proper—that is, of the science of the phenomena of mind in its normal conditions—is absolutely necessary. Without an acquaintance with the problems and methods of psychological inquiry it is impossible to observe and to describe adequately the phenomena of morbid mental states. In the investigation also of those conditions in which the disturbance of a single function is what is most manifest and striking, it is clear that a knowledge of the limits of differentiation of function must be of capital importance. It will be of value also to become familiar with the terms used in psychology, in itself a study of no inconsiderable difficulty and extent. In dealing with such questions as amnesia, aphasia, delusions and hallucinations, and other disturbances of consciousness, we are not only in the sphere of our legitimate activity and of our daily work, but we are touching, not indirectly, on some of the most interesting problems of mind. In examining these questions we get into one of the main currents of modern thought, and have suggested to us some problems which have engaged the attention of many of the acutest intellects of ancient and modern times. Some psychologists refuse to accept any help from physiology, and fortify themselves in the citadel of introspection, declining all external aid. It is said by them that the comprehension of physical processes throws no light on psychical processes, and that these are absolutely heterogeneous.

Now, in assisting in the solution of these grave problems I think our function as medical men is in the main a limited although a highly important one. Our obvious duty is to collect such a body of facts as will afford a sure foundation for future generalizations. Besides the the states of marked and more or less well-defined disease which enter of right into our nosological classifications we have a wide field in examining into the influence of habit and heredity, the cerebral peculiarities which, more or less transformed, descend from generation to generation, constituting an "innate preparedness" for the development of particular morbid phenomena; the relations between vice and disease; and the question of when criminality implies merely pathological conditions. Physicians cannot accept the position of mere *curiosi naturæ*; in presence of serious disease they must act with the best means they possess. Failing in this duty they would be justly liable to the reproach of Mephistopheles:

"To grasp the spirit of medicine is easy,
Learn of the great and little world you fill;
To let it go at last, so please ye,
Just as God will."

We must always remember it is by its utility to the world that medicine must ultimately stand or fall, but we must use the word utility in its widest significa-

tion as comprising, on the one hand, all the special activities of our profession in preventing or mitigating or removing human suffering, and on the other all its incidental advantages in aiding the development and progress of human intelligence by taking its position along with other members of the group of sciences of observation.

It will always also be of great aid to the physician to be able in dealing with those committed to his care to recognize the influence on them of ideas of hope, of confidence, of endurance; to be able to deduct from their complaints what is the result of an impressionable nervous system and what of pure imagination; to solve, as nearly as may be, the personal equation. These capabilities will supplement beneficially the most refined and accurate physical diagnosis. We need not doubt that the multiform aspects of disease, following, as they do, closely on the track of all the numerous and diversified forms of human energies and activities, will afford ample scope for the freest exercise of the highest scientific faculty as well as for the employment of the most minute and patient observation.

TREATMENT OF DELIRIUM TREMENS.

At a meeting of the British Medical Association, Dr. Kerr said that delirium tremens might be either a morbid condition produced by nervous exhaustion or a malady developed as an effect of alcoholic poisoning. He believed that it was the latter, and arose from the cumulative specific action of the poison on the cerebral tissue through the alcoholization of the blood. Acting on this belief, for some time past he had aimed at eliminating the poison as speedily as possible. So far as he knew, this plan was first suggested in 1854 by Dr. Alexander Peddie, who generally prescribed antimony. The most serviceable drug in Dr. Kerr's hands, however, had been liquor ammoniæ acetatis. The main point was to avoid the administration of alcoholic liquors, opiates, chloral, bromide of potassium, and the like. These drugs tended only to aggravate the symptoms. The best hope of cure lay in natural exhaustion inducing sound refreshing sleep. The differing results of narcotic and non-narcotic treatment were strikingly exemplified in the case of a publican who, when 48 years old, was treated for his second attack by opium and bromide of potassium, and in his third attack, two years later, by liquor ammoniæ acetatis. In the former seizure, though the narcotic draught at bed-time induced some sleep, the patient, after the second night, invariably awoke feeling confused and heavy, stuperose, and with no relish for even the lightest food; the only craving was for spirits. The delirium steadily became more intense, until it took four strong men to restrain him. The patient persisting in refusing food, dashing the cup with great force against the wall, whenever he had the chance, and becoming more and more maniacal, to save his life, as a favor, Dr. Kerr procured him admission into the workhouse. He was there put into a padded room, and left to rave and storm at his pleasure. Strong coffee was given to him, which he at first angrily refused, but, latterly, craved for, no medicine at all being administered. Though at first he was hardly expected to survive, he made a good recovery in a week, but felt very weak and languid for some weeks afterwards. His succeeding attack was characterized by even graver symptoms; he had a fit (apparently epileptic) in the early stage of the delirium. As it was, for various reasons, extremely undesirable that he should be taken to the workhouse again, he was treated at home. From first to last no narcotic nor anæsthetic was given. The only medicine used was liquor ammoniæ acetatis. A drachm was given every hour, till he perspired freely, and after that the dose was gradually diminished to 15 minims, the intervals being extended to four hours. In about seventy hours he had a short sleep, and in

four hours more quiet sound sleep which lasted for twenty hours. Thereafter, except when aroused to take nourishment, he slept naturally. All delusions and hallucinations disappeared on the fourth day of the attack. In eight days he was at his usual occupation again behind the bar. The contrast between the effects of the treatment during the two illnesses was most marked. During the first, when awake he was constantly delirious, heavily stupid, or violent, continually trying to get in and out of bed. During the second, he always awoke with head clearer, less confused, and a readiness to take food. During both attacks, milk and soda, beef tea, meat juice, and chicken broth were relied upon to sustain the strength. No alcohol was prescribed on either occasion. In incipient cases, or indeed during the height of the attack, Dr. Kerr would prefer, if its application could be relied upon, a hot or cold wet pack, frequently repeated if necessary, to induce sleep. But in the absence of a skilled bath attendant, he had found the liquor ammoniæ acetatis by far the most effective, acceptable and reliable remedy which he had tried. By this method of wooing natural sleep, the first step in the cure, the patient's brain and nervous system was left undisturbed by any narcotic or anæsthetic; and the *vis medicatrix*, which, after all, was the most powerful factor in recovery from disease, had "a fair field and no favor."

DIAGNOSTIC AND PROGNOSTIC VALUE OF TENDON REFLEXES.

Dr. John Ferguson (*Medical Record*) writes on this subject the following:

The physiology of the tendon reflexes is a matter of much dispute. Some maintain that they are of a reflex character and of spinal origin, while, on the other hand, equally competent observers consider that they are due to a mechanical excitation of the muscle, such as a blow upon its tendon. But there is not such a great difference between these views when both agree that the state of muscular irritability which causes the muscle to respond to excitation is due to a nerve-stimulus supplied to it from the spinal cord. The writer believes that the tone of the muscle is due to its normal and healthy connection with the spinal centre; and this latter receives its stimulus from the cerebellum, the cerebellar influx, and is held in check by the cerebrum, the cerebral inhibition. Derangement of this mechanism would result in either a deficiency, an exaggeration, or an abolition of the reflexes.

When the control of the cerebrum is removed by the occurrence of a hæmorrhage, the growth of a tumor, the existence of a degeneration, or an epileptic paroxysm, the muscular irritability increases and the tendon reflexes are exaggerated. In cases of cerebral hæmorrhage the tendon reflexes may be enfeebled or abolished, provided the apoplexy was of sudden origin. No special prognostic value can be attached to the *absence* of the deep reflexes in such cases, as the real causes of the abolition of tendon reflexes are the position and the suddenness of the hæmorrhage rather than its extensive character. In the great majority of cases of cerebral hæmorrhage the reflexes soon return. If there is any pressure on the cerebellum, however, the reflexes will not return as long as this pressure lasts. In cases of cerebellar tumor the knee-jerk is usually wanting, and cerebellar titubation may be present.

In cases of injury to the spinal cord, where the reflexes are absent after a lapse of several weeks, the prognosis is very grave, as the indications are that the cord lesion is a very serious one. In all diseases or injuries of the motor areas of the brain, causing a loss of control over the spinal cord, in all injuries and diseases of the motor paths, capsular, crustal, or pyramidal, by which the influence of the cerebral cortex is cut off from the spinal centres, there is developed a condition

of extreme excitability of the reflexes. Such conditions as spastic paralysis following some lesion in the motor tracts, primary spastic paraplegia, cerebral spastic paralysis of children, the ataxic paraplegia of Gowers, and multilocular sclerosis, are all conditions in which we meet with an exaggerated condition of tendon reflexes. The sooner the knee-jerk becomes increased in these cases, and the greater the degree of this increase, the worse must the prognosis be. After a careful study of a number of cases of general paresis the writer concludes:

1. When the knee-jerk is little affected, the disease in the cerebrum is not very extensive; and the more rapidly the disease increases the more rapid will be the increase in the knee-jerk.

2. When the knee-jerk is reduced or lost there is coincident disease in the spinal cord, either of the postero-external columns or of the anterior cornua.

3. If the disease be in the posterior columns there will be symptoms pointing to this, as found in tabes dorsalis.

4. When the cord disease is in the anterior cornua, along with the loss of the knee-jerk there will be flaccidity, atrophy, and degeneration of the muscles.

5. The loss of the knee-jerk, due to either of these morbid changes, would call for a very unfavorable prognosis, and would preclude much hope of even a temporary arrest of the disease.

THE EVOLUTIONARY SIGNIFICANCE OF DECAY AND DEATH.

In his lately published "Animal Life and Intelligence," C. Lloyd Morgan attempts from the point of view of evolution and natural selection to account for the introduction of death into our world. He thinks that natural decay and death may be the penalty the individual has to pay for increased strength and vitality in the earlier stages of life. Through natural selection those individuals have survived who exhibited predominant strength and vitality for a shortened period, even at the expense of natural decay and death. The increased life-power, not the seeds of decay and dissolution, was that which natural selection picked out for survival, or rather that which elimination allowed to survive.

In such ways—a short life with heightened activity being of advantage to some forms, a more prolonged existence at a lower level of vitality being essential to others—natural selection may have determined, in some degree, the relative longevity of different organisms.

This view is somewhat different from that maintained by Weissman, who believes that senility and death are no part of the natural heritage of animal life, but have been introduced among the metazoa on utilitarian grounds. "Worn-out individuals," he says, "are not only valueless to the species, but they are even harmful, for they take the place of those that are sound. Hence, by the operation of natural selection, the life of our hypothetically immortal individual would be shortened by the amount which was useless to the species. It would be reduced to a length which would afford the most favorable conditions of existence of as large a number as possible of vigorous individuals at the same time."

Seriously, the above attempted explanations of the why and wherefore of death in the animal economy seem to us to convey very vague hints. They do not suggest any good reason why an organism that can in the healthful performance of its nutritive and other functions maintain its integrity for one year or fifty, might not do so indefinitely, given a favorable environment, and serious accidents being excluded. We know octogenarians like Gladstone and Martineau who are no less useful to their species to-day than at any previous period of their lives, and they have remarkably retained their pristine strength and vitality. All that we really know of decay and death is that they come about inevitably

some time, in accordance with "a law of nature," and that "dissolution is the complement and necessary sequence of evolution."—*Boston Med. and Surg. Jour.*

ECZEMA IN INFANTS AND YOUNG CHILDREN.

Eczema cannot be named among the more serious diseases, but still you may meet cases at any time which will try your patience and baffle your therapeutic skill, and which, by the amount of suffering and sleeplessness caused the little patient and the worry and loss of rest to the parents and attendants, will sometimes rise to the proportions of a domestic calamity.

The infantile skin being peculiarly susceptible to external injury and irritation, it is not uncommon to see the milder forms of eczema spring up suddenly as a result of too much soap and water, of wet diapers, of slobbering about the neck, or merely from the rubbing and chafing of irritating clothing or exposure to the rigor of winter air in taking exercise.

The erythematous form of eczema here understood is characterized by a simple redness of the skin without infiltration, moisture, or discharge of any kind. It is not apt to be mistaken for any other disease, unless under exceptional circumstances, which I will mention in a few moments.

It is very easy for this condition, occurring in the tender skin of infancy, to run into another and more serious form of eczema, accompanied by exudation and maceration of the cuticle, or the formation of vesicles, and for this reason it should be checked at once. As it is almost invariably due to local irritation, the cause of this must be looked for and so far as possible done away with.

One of the commonest forms of erythematous eczema in infants is that often called intertrigo, and which is here due to the maceration of the buttocks, groins and thighs in the urinary and fæcal discharges retained in the child's napkin or diaper. When these discharges are normal they are rarely irritating, but an attack of indigestion or diarrhœa gives them an irritative character, and if the condition remains unchanged intertrigo and erythema supervene, and the condition soon goes on to the stage of moist eczema, usually beginning in the groins.

The appearance, which is at first only that of a more or less dusky redness of the skin, soon changes, and fissures occur in the fold of the groins and about the genitals and anus, the perspiratory secretion becomes rancid, and adds to the irritation and extreme discomfort, due to burning and itching, and pain on movement results.

In these cases the first thing to be done is to change the character of the alvine and urinary discharges. The fæces are apt to be white and curdy and very sour-smelling. Give minute doses of calomel and soda, sometimes adding a little rhubarb, and correct any possible errors in the infant's dietary, and you will soon find a change, not only in the character of the stools, but also in the urine. The latter, which is frequently somewhat scanty, highly colored, and acid, with occasionally some deposit of urates, becomes changed by the rectification of the intestinal disturbance.

Meantime you must protect the tender skin from the irritating fluids in which it is constantly bathed. Ointments and greasy applications will not usually suit, because they quickly become irritative. A careful cleaning of the skin with some mild soap and warm water, followed by careful drying with a soft towel and a coat of vaseline, is very effective in giving relief.

The proper soap for use in these cases is one as nearly neutral as possible. Almost all soaps used in washing infants are too alkaline.

If the eczematous condition requires local medication, a very mild astringent

lotion acts better than other forms of treatment in most cases. The black wash of the pharmacopœia, alone or with an equal quantity of lime-water, sopped on the skin or applied on soft rags in the folds of the skin, acts surprisingly well. Powders are so apt to cake and crust that they must be employed with caution; those containing starch should be avoided.

When there are cracks and fissures, ointment may sometimes be used. The black wash, followed by an ointment of oxide of zinc and vaseline in equal parts, may be applied in small quantities.

In those somewhat unusual cases where there seems to be little or no pruritus, an ointment of the boric acid (twenty or thirty grains to the ounce) may be prescribed. In other cases a drachm of subnitrate of bismuth to the ounce of ointment is of use. These ointments are best applied spread on linen rags or on strips of paraffin paper. They should be cleansed off from time to time by the use of warm water, because decomposition and irritation soon occur under such dressings.

Where there is pruritus, you would do well to have the various ointments employed rubbed gently into the skin in small quantities and at frequent intervals. The addition of from three to ten grains of carbolic acid to the ounce of the ointments mentioned above will soothe the itching in most cases. Tar or oil of cade, in the proportion of a drachm to the ounce of ointment, is an excellent antipruritic: it is much more disfiguring than the carbolic acid, however.

An excellent preparation in this form of eczema is the following:

℞.—Sulphuri precipitat.,
Picis liquidæ, āā ℥ss:
Ung. zinci oxidi, ℥i.—M.

Keeping in mind what I have said about the clinging properties of oxide of zinc ointment, you will not use this when there is much hair, but I know of no more generally useful ointment in these cases.

When the pruritic eczema is in the form of small patches, especially on the cheeks, and when the discharge is not very profuse, the following pigment is convenient:

Olei cadini, ℥i:
Collodii, f℥i.—M.

A camel's-hair brush should be fastened to the cork so as to be withdrawn with it, and the attendant must be instructed to keep the bottle closed.

A coating of this pigment brushed over the diseased skin acts as an antipruritic, and also protects the diseased patch from the air and, to some extent, from the hands of the little patient. When the disease is on the cheeks it is usually the most convenient application which can be made. The pigment stings slightly when first applied, but this discomfort passes away almost immediately. The child should be held firmly to prevent struggling during the laying on of the pigment, and care should be taken to avoid getting too near the eyes.

In some of the more chronic cases of eczema in children, when a few circumscribed, thickened, itchy patches extremely resistant to treatment represent the disease, it may sometimes be necessary to have recourse to strongly stimulant applications, with a view to excite enough reaction to carry off the infiltration. Tar in ointment of various strengths may be employed alone or combined with a mercurial ointment, as in eczema of adults. Washes of potassa caustica, from five to twenty grains to the ounce, may be applied by means of a small swab brushed over the surface. These applications should not be allowed to remain, but should be quickly washed off and followed by a soothing ointment. They

should be applied cautiously at first, remembering the more delicate character of the child's skin.

Arsenic is a drug so commonly employed, even at this day, in the treatment of eczema of all kinds that you will naturally expect me to say something about it; but I must distinctly state, as the result of a very extensive experience in the use of this drug, that, in my opinion, it has no specific effect whatever upon the course of eczema, and that even as a tonic its use is limited. In children, disturbance of the digestion is frequently the most marked result of its administration, and through this the disease may be, and sometimes is, rendered worse.—Dr. Arthur Van Harlingen, *Int. Med. Mag.*

ON THE FUNCTIONS OF THE TONSILS.

Dr. G. L. Gulland, in the *Western Medical Reporter*, draws the following conclusions:

1. The tonsils—faucial, lingual and pharyngeal—are organs arranged to further the reproduction of leucocytes.

2. This reproduction takes place, mainly in the germ-centres, by mitotic division of pre-existing leucocytes.

3. The young leucocytes so formed are partly carried off to the general circulation by lymphatic vessels originating in the tonsil, partly remain in the tonsil as "stationary" cells, and partly wander out into the crypts by perforating the epithelium.

4. They thence pass to the surface of the tonsils, and take up foreign bodies, especially micro-organisms, which would otherwise pass the tonsils.

5. In the human subject, the lingual and faucial tonsils, and the slight diffuse leucocyte infiltration of the under surface of the velum palati, form a protective ring or zone between the mouth and the rest of the alimentary tract; while the pharyngeal and tubal tonsils and the diffuse leucocyte infiltration of the upper surface of the palate form a protective ring round the upper part of the respiratory tract.

6. There is no reason to regard the tonsils as having any absorbent function in normal circumstances; the reproduction of leucocytes is sufficiently active, as a rule, to keep up a continuous outward stream of these cells, and to prevent the entry of foreign substances into the tonsil.

7. Under certain circumstances, for instance in general debility, the reproduction of leucocytes may be interfered with, or the outward stream of these cells from the tonsils may be arrested. This arrest or other circumstances interfering with the activity of the leucocytes may allow pathogenic organisms from the mouth, etc., to enter the tonsil by the spaces in the epithelium, and these microbes may give rise to a local or general infective process.—*Merck's Bulletin.*

STERILITY.

In answer to the statement of Dr. H. F. Campbell that mental exertion is a cause for sterility, Dr. Mary A. Dixon Jones writes:

I was for years a student in one of the largest and most advanced colleges for women then in this country. The students pursued a collegiate course of study, embracing the higher branches of mathematics, the natural sciences, intellectual and moral philosophy, English literature, belles lettres, etc. Many of the young ladies, besides, had heavy tasks daily in the classical and modern languages. Afterwards as a teacher I was in the college four years, and, later, was for two years in another college, equally distinguished and equally advanced, and for a number of years I was principal of a young ladies' seminary of a high grade, which demanded about the same course of study. During this period of

thirteen or fourteen years, over three thousand young ladies came under my observation, who during the period allotted to sexual development were subjected to continuous "severe and laborious intellectual labor;" yet in all this number and in all these years, I do not recollect a single one giving any indication that "the reproductive organs were not naturally and promptly developed," and that, "their functions were not normally performed." The young ladies were under my observation at all hours of the day, yet in all of these years, among so many young women, I do not remember one who had apparently any difficulty with the function of menstruation, or suffered so that her studies were in the least interrupted, or that it was necessary to lie in bed; except, perhaps, in one instance, and this young lady did so at the periods on a few occasions, because she wanted, as I imagined, a chance to read Browning's poems, or write imitations of the same. I would have been apt to have noted any sickness, as I was then reading medicine; and, besides, during all these years physiology was one of the branches I was studying or teaching.

The young ladies who were subjected to these severe intellectual tasks grew healthier and stronger. They had their regular hours for recreation and sleep; still severe intellectual labor was demanded, equally heavy as long continued, and for as many years as young gentlemen have at college; yet the young women were not made sterile thereby, or invalids, nor did they lack in any way perfect development. Most of them afterwards married and had large families of children.

I have known "the first honor girls" for many successive years; girls who gave themselves up to the closest and most "laborious intellectual labor," and who, for their greater medical discipline and profounder intellectual attainments, stood first. They were emphatically "women of the highest intellectual type;" yet I did not know one who "fulfilled the destiny of a childless woman." I recollect one with her pretty blushing face; she married; children came in quick succession until her table was surrounded by young and happy faces. Another "first honor girl" accustomed always to out-stripping the members of her class, when married and settled in a large city, equally successful in out-stripping her neighbors in the number of her children.

A "first honor girl" of another school, a student, a writer and a public speaker, yet is blessed with more than the usual number of children, and has the strength to look after these children and after her household affairs, besides doing much outside work in blessing humanity. "She girdeth her loins with strength and openeth her mouth in wisdom."

If study prevents development, by diverting the vital forces from the sexual organs at the very time when their exercise is most needed, will not the same principle apply to boys pursuing a college course? What is the difference? "Male and female created He them." Woman is subjected to the same laws of health as is man, and like him she is capable of high mental cultivation, and, at the same time, of retaining the full power of her procreative functions.

Dr. H. F. Campbell instances the savage, half-civilized Indians and Negro women of Southern plantations. There are many Indian women who are sterile, who have anteflexion, and who suffer from these infirmities, and who die young an account of complications. Women's physical paradise is not among the savage or the semi-civilized Indians.

As to the Negro women on Southern plantations, I was born south of Mason and Dixon's line, and I know that many of the colored women are sterile; many do not have prosperous gestation, or easy parturition, nor numerous offspring.

It was among these women that Marion Sims was led to study the remedy for vesico-vaginal fistula, showing that the parturitions were not always easy.

Properly educating and training the mind does not render any organ less capable of performing its normal functions. To insure the highest degree of development, both bodily activity and mental culture are essential —*Times and Register.*

EXAMINATION OF THE BLOOD FOR GONOCOCCI.

According to L. Jullien, gonococci are found in the blood not only in cases of gonorrhœa, which are complicated by rheumatic affections, but also in those which are complicated by cystitis and orchitis. This view has been disputed by Welander, Aubert, Roux and others. F. Trapesnikoff (Medycini, 1892) has examined the blood in thirty-two cases where gonococci were present in the discharge, the gonorrhœa being complicated by epididymitis, orchitis, cystitis, prostatitis, arthritis and paraplegia. He failed, however, to find gonococci. His conclusions are as follows:

1. In cases of gonorrhœa, where the complications mentioned by Jullien were present, no gonococci occurred in the blood.

2. Without denying the possibility of gonococci entering the blood, their presence can be much less frequently determined microscopically than Jullien has stated.

3. The presence of gonococci in the pus in gonorrhœal arthritis and other complicating affections may be due to the entrance of microbes in the lymph channels.

4. In cases where the direct action of gonococci cannot be demonstrated, the complications of gonorrhœa are brought about either by the extension of the inflammatory process *per continuatem* or through the agency of toxines.

5. The constant occurrence of gonococci in pus cells and leucocytes is not available in the differential diagnosis of this microbe.—*Oest. ungar. Centralbl. f. d. medicin. Wissensch.*—*International Journal of Surgery* for August.

A CASE OF COCAINISM.

Percy Smith records (*Journal of Mental Science*, July, 1892) the case of a nurse, aged 39, who entered Bethlem Hospital as a voluntary boarder for the cocaine habit. She was a German by birth, and had previously been addicted to the use of morphine and laudanum, and her mother had been the victim of the morphine habit. She had commenced to take cocaine about eight months previously, and had gradually increased the dose until 10 grains was her usual quantity, though she occasionally took 24 and even 36 grains at a single dose. For the first six hours after a dose of 10 grains she felt more able and inclined for work whilst sitting, but she could not go about, as it produced a feeling of weakness; at the end of that time she would be disinclined to do anything and would lie down, but could not sleep; about a quarter of an hour after a dose she usually suffered from vertigo for an hour, and from palpitation for some hours; she had also great dryness of mouth, thirst, and anorexia. After a large dose there was difficulty in swallowing. She had hallucinations, and imagined she saw people and heard them talking to her, and used to carry on conversations with them although she knew they were hallucinations. The hallucinations soon disappeared after her admission, and after four months, including a stay in the country convalescent home, she left apparently well, and two months later reported herself as quite well.

TREATMENT OF DIARRHŒA BY SALOL.

Dr. M. H. Fussell, speaking of the treatment of diarrhœa by salol, says that

where he formerly used opium almost universally, he now almost universally omits it from his prescriptions, making use of it as an adjuvant where salol fails to control the symptoms. He uses the following prescription:

℞.—Salol, ʒj.
Bismuth subnit, ʒij:
Mist. cretæ, q. s. fʒiij.

M. et Sig.—ʒij, every two hours.

He concludes as follows:

1. Diarrhœa due to dietetic errors, and that which is common in adults and infants in summer, is well controlled by the administration of salol and bismuth or chalk.
2. Opium is rarely necessary where salol is used.
3. Salol controls the abdominal pain equally as well as opium.
4. It is perfectly safe, having no bad after-effects.
5. It is especially useful in the treatment of the diarrhœa of children.
6. It is of no value in dysentery.
7. It constantly corrects the fœtor of the stools.—*Therapeutic Gazette.*

DOUBLE OVARIOTOMY.

An interesting communication by M. Polaillon to the Academie de Medicine has reference to a woman who, in spite of a double ovariotomy performed in the third month of pregnancy, was nevertheless delivered safely at term. The history of the case is briefly as follows: First symptoms of the existence of an ovarian cyst appeared at the age of twenty-three, the patient being nulliparous. At the age of twenty-nine, menstruation having ceased for several months and symptoms suggestive of early pregnancy having appeared, severe pains in the abdomen suddenly developed. Examination revealed the presence of an enormous ovarian cyst, probably suppurating, the state of the patient being so serious that, despite the suspician of pregnancy, it was decided to perform ovariotomy at once. At the operation, M. Polaillon came upon a large cyst of the left ovary, adherent to the intestine and to the Fallopian tube of the same side. The adhesions were ruptured, the proceeding giving rise to profuse hæmorrhage. The left ovary having been removed it was found that the right tube was the seat of hæmorrhage and that the right ovary, which had attained the size of an apple, was likewise affected with cystic degeneration. The right organ was in its turn removed. Recovery proceeded satisfactorily and the woman was in due time delivered, the labor presenting no unusual features and the placenta being normal. The cicatricial line was not injuriously distended during the evolution of pregnancy. The lesson deduced from this case by M. Polaillon is that pregnancy may continue after the removal of the upper portions of the broad ligaments and despite the interference with the uterine and placental circulations entailed by the suppression of the superior uterine bloodvessels. He attributes the excessive hæmorrhage which occurred during the operation to the extra vascularity of the parts due to the gravid condition of the uterus.—*Lancet.*

Recommendations of Therapeutic Agents.

PHENACETINE IN THE NERVOUS SEQUELÆ OF LA GRIPPE.

In an article read before the American Medical Association, Detroit, June 7, 1892, Dr. Wm. F. Hutchinson, of Providence, R. I., presented the differences existing between the course of the epidemic of grippe of last season, and that of

previous years. In New England, Dr. Hutchinson observed several novel symptoms, which were quite refractory to treatment. Later, on a visit to the tropics, he found a similar course of symptoms, with a more severe general condition and a higher death-rate. At the same time there was less pneumonia than in the North, and the fatal terminations appear to have been largely due to nervous complications. Dr. Hutchinson recognizes the fact that where so many pyschic maladies have developed from influenza, the latter must be regarded as a sufficient cause for them, and the matter to be considered is the proper treatment to be instituted. The writer first names as follows, the special symptoms of neurotic grippe: Insomnia, loss of appetite, progressive physical debility, perversions of sense, impairment of cardiac nerve-tone, hallucinations, delirium and insanity. To these he adds certain paralyses, formication and other reflexes, pain and hyperæsthesia of the skin. Concerning treatment, the writer says that opium must be barred from the beginning. "When," he remarks, "in the cases under consideration, any of the opiates are administered in sufficient quantities to produce sleep or relief from pain, disturbance of general function and subsequent reaction are too pronounced to permit of their continuance and depression too profound to allow them to be continued or even repeated. Something was needed that could be given for a length of time without increase of dose or loss of effect; for neuroses following grippe are usually of long duration." "Sulfonal," said the author, "produces sleep, but does not relieve pain. Antipyrine and antifebrine disturb heart action to a degree occasionally alarming. Chloralamid is better, but loses effect after continued administration. The various preparations of ether are too stimulating to circulatory centres, and choice seems to lie between such vegetable narcotics as hyoscyamine, hyoscine and the like, and phenacetine. In a few instances I did well with a combination of hyoscine and monobromide of camphor, but in a majority the phenol derivative (phenacetine) has proved to be the best. Indeed, were it not for a peculiar quality which phenacetine possesses, and sometimes brings into action, that of producing perspiration, it would be the ideal hypnotic and pain-killer; and with this defect, which I have usually been able to correct by using it with quinine sulphate, in my opinion phenacetine stands first in the list of remedies for the relief of insomnia and pain in the permanent neuroses following grippe. No general dose can be stated, but I consider the drug harmless in any quantity that is likely to be found necessary, and have given ten grains every two hours for two days with no bad result. Phenacetine may be combined with iron for long administrations, and, in that form, presents the best tonic with which I am acquainted for the adynamic conditions of long continued prostration, from whatever cause."

Medical Items.

The New York Pasteur Institute, which was established and conducted by Dr. Paul Gibier, has been closed owing to the want of funds.

The Tri-State Medical Association of Mississippi, Arkansas and Tennessee, will meet in Memphis on Thursday, November 17.

Dr. William Henderson, Professor of Clinical Medicine, in the Royal Medical College, Kingston, Ont., died August 14, after two weeks' illness, from Bright's disease. He was thirty-six years of age and a member of many medical societies.

Professor Hare said that it is no use to give cod-liver oil after there are tubercular deposits in the lungs. It is absolutely harmful in the majority of cases, as it disorders the stomach, and very frequently gives rise to an oily diarrhœa.

The Southern Surgical and Gynæcological Association will be held in Louisville, Ky., on November 8, 9, 10. Those proposing to assist in making the meeting a success by the contribution of papers should notify the Secretary, Dr. W. E. B. Davis, of Rome, Ga., at the earliest convenience.

"It is estimated that ninety million dollars worth of fraudulent food products are annually disposed of in the United States, either mixed with good articles or sold in place of them." "No wonder Cousin Jonathan suffers from indigestion."—*Brit. Med. Jour.*

Dr. Charles Warrington Earle has been called to the chair of Obstetrics and Diseases of Children, in Rush Medical College, recently made vacant by the death of the late Professor Knox. Dr. A. C. Cotton has been elected Clinical Professor of Diseases of Children.

Dr. Chas. E. Sajous, editor of the *Medical Annual*, has been appointed a Knight of the Legion of Honor of France, by President Carnot, for his services to the French colony, and to science. As an American of French descent, Dr. Sajous went to Paris last May to translate his *Medical Annual*, and he expects to make Paris his home for the next three years.—*Times and Register.*

The Twenty-third Annual Meeting of the Medical Society of Virginia will be held at Alleghany Springs, September 13th, 14th, 15th and 16th. The object for general discussion will be "Vertigo." The discussion will be opened by Dr. E. T. Brady, of Marion, and continued by Dr. L. C. Gray, of New York. The following papers are announced: "Appendicitis," by Dr. William Edward McGuire, of Richmond, Va.; "Laparotomy and the Good Accomplished by It in Gynecology," by Dr. R. S. Martin, of Stuart, Va.; "Some New Ideas that are Old," by Dr. S. W. Dickinson, of Marion, Va.; "Necessity of Prompt Action in Cases of Placenta Prævia, with Report of Cases," by Dr. L. H. Keller, of Luray, Va.; "Some Ocular Diseases in Children," by Dr. Philip Taylor, of Richmond, Va.; "Mysteries of Medicine," by Dr. C. W. Gleaves, of Wytheville, Va.; "Injuries of the Knee: Their Treatment and Results, with Special Reference to the Prevention and Cure of Suppurative Action in and about the Joint," by Dr. M. W. O'Brien, of Alexandria, Va.; "The Causative Relations of Bacteria to Disease," by Dr. C. M. Blackford, of Lynchburg, Va.; Common-Sense in the Treatment of Discharge from the Ear," by Dr. Alexander Duane, of New York, N. Y.; "Some Uses of the Iodides," by Dr. L. G. Pedigo, of Roanoke, Va.; "Cataract," by Dr. Joseph A. White, of Richmond, Va.; "Some Remarks on the Continued Administration of Digitalis, Illustrated by the Report of a Case," by Dr. F. M. Brooks, of Fairfax Station, Va.; "Uterine Hæmorrhage and Present Method of Treatment," by Dr. A. Vander Veer, of Albany, N. Y.; "Surgical Management of Fibroid Tumors of the Uterus," by Dr. Joseph Price, of Philadelphia, Pa.; "Modern Electrical Methods as a Substitute for Surgery in Certain Pelvic Affection," by Dr. G. Betton Massey, Philadelphia, Pa.; "Sexual Hypochondriasis and Perversions of the Genesic Instinct," by Dr. Irving C. Rosse, of Washington, D. C.; "What shall be done with the Imbecile?" by Dr. Samuel J. Fort, of Ellicott City, Md.; "Hypnotism as a Therapeutic Agent," by Dr. William Lee Howard, of Baltimore, Md.

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CONTENTS

ORIGINAL ARTICLES.

Idiopathic Pericarditis. By S. K. Merrick, M.D., Baltimore. 969

Report of an Operation for the Cure of Umbilical Hernia. Reported by Clara S. Earley. . 972

Report of Laparotomy for Removal of Ovaries. Reported by Amelia M. Fendler, Ph. G. . 974

EDITORIAL.

"Co-operation;" not "Competition." . . 976

Publish Your Own Experience. . . . 977

MEDICAL PROGRESS.

Eclampsia and Septicæmia.—Fluids with Food.—Condemnation of Tuberculous Meat.—The Influence of Parturient Lesions of the Uterus and Vagina in the Causation of Puerperal Insanity.—Surgery of the Thorax.—Electricity in Gastralgia.—Therapeutics of Constipation; New Remedies.—The First Hospital in Montreal.—Nitro-Glycerine in Nephritis.—Malaria in Italy.—Note on Diastasis Through Neck of Femur.—Report of French Commission on Cholera. 978

MEDICAL ITEMS. 988

Original Articles.

IDIOPATHIC PERICARDITIS.*

BY S. K. MERRICK, M. D.,

Professor of Diseases of the Nose, Throat and Chest, Baltimore Medical College.

This term is used by authors to define an inflammation of the pericardium (which may be acute, sub-acute or chronic) not the result of any discoverable preceding or concomitant pathological process. In other words, it is used to distinguish this form of pericarditis from the secondary variety, or that dependent upon some other disease. It is a common observation that acute articular rheumatism and Bright's disease are by far the most frequent causes of pericarditis. Some of the other diseases which stand in an etiological relation are pleuritis, pneumonia, phlebitis, typhus, typhoid and the eruptive fevers, scurvy and acute alcoholism. DaCosta says: "Pericarditis does not occur in chronic rheumatism, and it is doubtful whether it may be occasioned by gout. Traumatism is probably quite frequently the cause of what is denominated simple or idiopathic pericarditis and diagnosed as such. Blows from the fist, which have been forgotten, have no doubt often caused pericarditis, not to mention other sources of trauma. To eliminate every etiological factor in any given case, and by exclusion arrive at a diagnosis of idiopathic pericarditis, requires no little pains and care on the part of the practitioner. Not a few authors are skeptical as to its existence."

*Read before the Clinical Society of Maryland.

DaCosta, while admitting its extreme infrequency, says he has seen several cases about which he has no doubt as to the diagnosis. The opinion of so careful, competent and experienced an investigator would naturally carry great weight. "Why the pericardium should be the particular membrane selected to take on inflammation as a complication to other affections has baffled the best endeavors of the most careful inquirers to determine." This granted, it is not unreasonable to suppose it may be the primary seat of inflammation. The morbid constituents of the blood in certain pathological conditions are admitted to act as an exciting cause.

Symptoms.—In Pepper's System of Medicine, p. 773, under this heading, is the following: "The symptoms of pericarditis may be so slight as not to attract attention. When they are noticeable we find pain, or a sense of uneasiness, or of pressure, with or without tenderness in the pericardial region. The pain or uneasiness is not infrequently accompanied by pain or tenderness in the epigastric region when pressure is made upon it. This arises from contiguity of the part and pressure of the diaphragm against the inflamed and tender pericardium. The pain is sometimes preceded by a chill of varying intensity, and is followed by febrile symptoms of greater or less severity; but these may be so slight as to escape the observation altogether, except by taking notice of the markings of the thermometer." I quote the foregoing to show how *slight* may be the symptoms, which initiate a case of pericarditis, and as particularly relevent to the cases which I shall report. It may be that the paucity of cases of idiopathic pericarditis reported depends in no small degree upon the obscurity of the symptoms and latency of the affection, which may possibly be characteristic of this form of the disease. Unless all clothing is removed from the chest and a most careful physical examination is made, many cases will escape detection. Even when this is done there will be some cases where no diagnosis can be made ante-mortem. One of my cases was not diagnosed, but belongs to the class of cases which all agree cannot be certainly diagnosed before death. It is not the purpose of this paper to dwell on the difficulties or methods of diagnosing pericarditis, but to mention certain facts in connection therewith, which have a special bearing upon the cases which I report. It may be stated that when no fluid is present, and no friction or new-leather sound is heard, the diagnosis of pericarditis is unwarranted. Where the sac becomes adherent to the heart, either partially or completely, there generally results one of two conspicuous deformities, viz.: Hypertropy, or atrophy of the heart. The latter condition was found at the autopsy held on one of my cases.

Ziemssen, vol. VI, pp. 219 to 224, divides atrophy of the heart into three kinds, viz.:

1. Simple atrophy, with normal size of cavities and thinning of the walls.
2. Concentric atrophy with diminution of cavities and thinning of walls.
3. Eccentric atrophy with dilatation of cavities and thinning of walls.

Case I, which I shall report, falls under the the first division. With these

prefatory remarks I shall now report my cases as a contribution to the literature of idiopathic pericarditis.

Case I.—Mrs. A., widow, age 60, came to the N. W. Dispensary in the early part of the year 1887 and visited the throat and chest department at pretty regular intervals until the fall of the same year. She complained of pain in the precordial region, of great weakness, and faintness on exertion, and her hands and feet were always cold. She had had no acute illness for years, never had rheumatism, nor any of the diseases which stand in an etiological relation to cardiac diseases. Her urine was examined and was found to be normal.

Careful auscultation of the heart failed to discover evidence of valvular disease: on the contrary, all the valvular sounds were clearly audible, but weak. The apex-beat was in the normal position, but lacked force. The only diagnosis made was a weak heart from malnutrition, the latter being due to some unknown cause. She was slightly jaundiced—her skin being very much like parchment.

The treatment consisted mainly of heart-tonics, stimulants, stomachic tonics and an occasional small dose of calomel. She grew gradually weaker under the treatment and progressively emaciated, the coldness of the extremities reaching up to the elbows and knees. Her condition rendered it necessary for her to go to the Md. Gen. Hospital in the fall of 1887. She was under my care for nearly three months, when she died. All treatment failed to be of any appreciable service, and no symptoms worthy of note developed while here, except the remarkable coldness. Sub-normal temperature is not infrequent among old persons, but this was the most remarkable case of the kind which ever came under my observation.

To the touch she was more like a cold-blooded animal than the *genus homo*. No attendant in the hospital ever found her normally warm during the three months while here; her urine was repeatedly examined and it was always found to be normal.

When she died I was notified and an autopsy was held by my late friend, Dr. E. R. Walker. Besides him and myself, there were present the resident physician, Dr. Hutchinson, and a number of students.

The heart and lungs were removed—the latter being sound and free from adhesions to the pleuræ or pericardium. The valves of the heart were perfectly sound, but the walls of the heart were atrophied and thin and on close examination there was found a uniformly adherent pericardium, which could be peeled off. The whole organ was firmly compressed by the adherent sac. All other organs were normal except the liver, which on close examination was found to contain small points of scar-tissue, here and there, the sites of former localized hepatitis, no doubt.

The coronary artery had doubtless been compressed by the adherent sac and thus the nutrition had suffered.

Case II.—M. H., widower, age 42, salesman in a clothing house, was admitted to the Maryland General Hospital, November 10, 1891.

His health had been very good until three weeks previous, when he had considerable pain about the precordia. He said he had no fever at any time. His temperature was repeatedly taken while in the hospital, and it was always normal. Urine examined a number of times and was always normal. He had never had rheumatism in his life or any disease to which I could refer the pericarditis found. I saw this case the first time at my out-door clinic, to which he had been brought by my assistant, Dr. Smith, for a diagnosis. Inspection failed to discover anything abnormal about precordia except the absence of the apex-beat, or impulse. Nor could the impulse be felt on palpation. No friction fremitus on palpation. Percussion revealed an increased area of dulness over lower cardiac region, but the pyramidal shape so often spoken of in pericardial effusion was not made out. DaCosta believes more stress is laid on this sign than properly belongs to it. Auscultation discovered the to-and-fro new-leather sound, heard with increasing loudness as the ear approached the base from the apex—a rather loud aortic regurgitant murmur was heard in the second right intrenched space—the blowing character of which was in sharp contrast to the pericardial friction sound.

The diagnosis was clear and I pronounced the case as pericarditis, with effusion, complicated with endocarditis and aortic and valvular lesion. Meeting Dr. Streett as I left the dispensary, I began to tell him of the case, when he requested me to first let him give his diagnosis, as he had previously examined the man without my knowledge. His diagnosis corresponded exactly with my own and we had both taken special interest in the case because it appeared to be one of idiopathic pericarditis. This man remained in the hospital only a few days after my attention was called to him, and, disobeying certain rules, he was dismissed, much to my regret.

843 N. Eutaw St.

REPORT OF AN OPERATION FOR THE CURE OF UMBILICAL HERNIA.*

REPORTED BY CLARA S. EIRLEY,
Clinical Assistant.

M. K., white, aged 26 years, married, had one child five years old. About three years ago, she noticed a small lump above the umbilicus, which increased in size till it became as large as a cocoanut, when it commenced to discharge, and discharged about one-half pint of pus in a day. This was about one year ago. From then till the time of the operation she was compelled to keep napkins over the hernia to keep it clean. She stated that about the time it commenced discharging she went to a prominent hospital in town to have an operation done for the cure of it; but instead of operating on the hernia they operated for the cure of a lacerated perineum from which she had never suffered inconvenience, and said nothing more to her about the hernia.

*In the Service of Prof. B. Bernard Browne, M. D., at Good Samaritan Hospital.

She came into the hospital (Good Samaritan) November 19th, 1891, when the diagnosis of sloughing, irreducible, umbilical hernia was made, and the day following was set for the operation. That night she was given an antiseptic bath and vaginal douche, and later on a dose of Rochelle salts to cleanse the bowels well. The next morning she was given nothing to eat. Fifteen minutes before the operation she was given a hypodermic injection of sulphate of morphia, ¼ grain, and sulphate of atropia, 1-200 gr., to quiet, and lessen the amount of anæsthetic to be given.

While the patient was being anæsthetized with chloroform, the abdomen was well scrubbed with soap and hot water and afterward with bichloride of mercury; then towels wet with bichloride were laid, one over the lower part of the abdomen and another at the waist. An incision was made vertically through the different layers. When the sac was opened a large quantity of pus escaped. The sac contained a large portion of sloughing omentum, but no intestine. The ring, which was very small and thick, was enlarged upwards, the omentum ligated below the slough in three places, as there is less danger of the ligatures slipping off if ligated in several places. The sloughing portion, weighing about two pounds, was cut off, and the stump returned to the abdominal cavity, which was then well irrigated with hot, boiled water. The sac and redundant integuments were then cut off, the edges of the ring refreshed and brought together with deep silk sutures. Then the edges of the wound were nicely pared and brought together with both deep and superficial silk-worm gut sutures, and the wound closed without a drainage tube.

The wound was dressed with a rubber protective, bichloride gauze, cotton and bandage, and the patient put to bed. That night, she being restless, a hypodermic injection of morphia, ¼ grs., was given and repeated several successive nights.

For three days she had considerable nausea and vomiting, with a rise of temperature; but after her bowels were moved the temperature went down and the vomiting stopped.

On the fifth day, when the dressing was removed, there was a slight discharge of pus. The stitches were all removed but one, which was left to hold the edges together, and the wound was well washed and redressed.

On the sixth day the wound was again washed and redressed.

On the seventh day the discharge was very slight, but it was found that the stitch left was not sufficient to hold the edges of the wound together, as the abdominal walls were so very thick, so it was removed. Then poultices were applied every four of five hours for several days, with a good result. When they were discontinued a dry dressing of iodoform and boracic acid, equal parts, was applied.

The wound being still not entirely healed, the edges were separated with adhesive straps and the base touched with a 10 per cent. solution of nitrate of silver every three or four days, and the wound left to heal by granulation.

On December 18th, the 28th day after the operation, she was discharged from the hospital, cured.

REPORT OF LAPAROTOMY FOR REMOVAL OF OVARIES.*

REPORTED BY AMELIA M. FENDLER, PH. G.,
Clinical Assistant.

Before describing the successive steps of this particular operation, I think it would not be out of place for me to say a few words in reference to the preparatory treatment and the care of patients prior to resorting to an operation of such magnitude. Previous to an operation of this kind the patient should be put upon a tonic course of treatment if this is in any way practicable. Generous diet should be given and such tonic drugs as iron, quinine, strychnine, employed. It is also well for these patients to take gentle exercise, never to fatigue, and to make their own surroundings as cheerful as possible. The operation should only be done upon consent of the patient, and the chances for her recovery should be made clear to her. After she decides upon the operation then the surgeon should express hope for its success, to keep up the patient's spirits.

As to the operation itself, it should always be performed in a locality where the air is pure and healthy; never in the wards of a crowded hospital. The day selected for the operation should be clear and neither too hot nor too cold. The temperature of the room should be kept at about 80°F., and the air moistened by the evaporation of water, or, better, of carbolic acid solution in a spray devised for the purpose. There should be present besides the operator an efficient nurse and four assistants—one to administer the anæsthetic, one to stand opposite the operator and aid in handling the abdominal wall, one to take charge of instruments and one to apply ligatures, cautery, to irrigate, etc.

The patient is M. F., age 21, colored, married. Has had two children, the last one born two and one-half years ago. Menstruation always has been regular as regards time, but the flow was profuse. Uterus enlarged, cavity being four inches in length and giving evidence of being in fibroid condition. Patient has complained of her present symptoms for about a year, the most prominent being pain in the lower part of the abdomen and also pain in the back. There has also been quite severe leucorrhœa. Patient was put under the influence of chloroform after being given a hypodermic injection of morphia sulphate, one-eighth grain, atropia sulphate, one two-hundredth grain.

After the patient was thoroughly under the effects of the anæsthetic an incision was made in the median line (linea alba) about three inches in length. First incision was through integument, then superficial fascia was divided and the incision was deepened down to the fibrous sheath of the recti muscles. There was slight hæmorrhage from superficial vessels. The peritoneum was punctured and a slit was made for the length of the external incision. There was a considerable flow of straw-colored serum. After this was cleaned away the omentum was exposed, and the sac of a small ovarian cyst came into view. A loop of intestine was found adherent to the ovary and cyst. The hands of the operator were rapidly cleansed of the blood which had collected on them, and his hand

*In the Service of Professor B. Bernard Browne, M. D., at the Good Samaritan Hospital, Oct. 28, 1891.

was introduced into the peritoneal cavity. There were found a great many adhesions, which showed the existence of long-standing peritonitis.

These adhesions were broken up with the hand, care being taken to let no discharge get into the peritoneal cavity. Then the left ovary was drawn over into the wound, after careful digital examination, and was found to be the seat of two small, transparent cysts. A small loop of intestine was found adherent to this ovary and when it was separated about an ounce of pus exuded, which was carefully washed away. I would state that the temperature of the patient on the evening of the day preceding the operation was 101°F. There was also considerable hæmorrhage at the time, which was checked with no little difficulty. A ligature was placed around the tube, and the ovary, tube and portion of the omentum were removed, and the stump returned. After exploration the other ovary was brought out, but not until after considerable adhesions had been broken up. This was removed in the same way as the other. Then the parts were thoroughly cleansed, the peritoneal cavity irrigated with hot water, glass drainage tube inserted and six deep silk-worm gut and one silk suture inserted. Parts washed again and patient bandaged. During the latter part of the operation the condition of the patient was very poor and two hypodermics of whiskey were given, after which the pulse became better. Six hours after operation the patient was very restless, but pulse and respiration were normal. Pulse 80, temperature 100⅘°.

I have visited the patient twice daily and taken pulse and temperature. Her general condition has been good. From time to time hypodermics of morphia have been administered to relieve pain. She has had nothing by stomach thus far except hot and cold water, magnesium sulphate to open bowels, and beef tea. Tube removed third day after operation, stitches the fifth day. My last visit made November 2, 1891, at 8 A. M. I found the wound still discharging, and the patient resting after a night's repose, with a temperature of 100° F., and a pulse of 120. From November 2nd, the evening upon which the case was reported to the Society of the Woman's Medical College, of Baltimore, the patient rapidly improved. On November 15th, eighteen days after she was operated upon, she was able to leave her bed. She rapidly gained strength, and on November 25, 1891, left the hospital, cured.

"The remedy," says Dr. G. B. Wood, "which we have found most effectual in the permanent cure of a disposition to the accumulation of flatus in the bowels, is an infusion made with half an ounce of columbo, half an ounce of ginger, a drachm of senna and a pint of boiling water, and given in the dose of a wineglassful three times a day."—*Pacific Medical Journal.*

Dr. Sweart, in *Vis Medicatrix*, advocates the use of a solution of scale pepsin in large abscess cavities. He says that it liquefies the pyogenic membrane and dead tissue. The cavity should afterwards be cleaned daily with peroxide of hydrogen.

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Editorial.

"CO-OPERATION;" NOT "COMPETITION."

One of the most important questions which meets the physician at the outset of his career is the determination of his relations to other physicians who are practising in his community. Shall it be one of friendship and good-fellowship; or shall it be one of rivalry and hostility?

On the one side he will find those quiet practitioners of the neighborhood who follow, perhaps without knowing it, the noble principles of the "code of ethics," being guided by the simpler principle of "doing unto others as you would have others do unto you." They believe that it is for the best interests of both the profession and the public that stability should be encouraged in the relations which exist between physician and patient; and that when these relations have once been deliberately established they should not be severed without mature reflection and just cause. They consider that when a physician has, by years of faithful work and skilful treatment, gathered about him a circle of patients, it is not right for other physicians to endeavor by artifice or allurement to seek to take them away from him. As long as he is faithful and efficient in his attendance he has, as it were, a prior right to their allegiance.

On the other side are those who regard the practice of other men as their natural prey. If they are newly settled in a community they at once manifest predatory habits. They "get up a big reputation" as soon as possible by rushing about in wild haste, lying about their practice and income, getting on "friendly terms" with the newspaper reporters, and doing "wonderful (!) operations." Their progress in a community is very similar to that of the Spanish in Mexico and Peru, if they are stronger than those upon whom they have decended. If they are men of unusual skill and business ability the gold and glory which they seek flow in upon them in steady streams. If, however,

they are men of only ordinary ability, their career is soon closed by the united hostility of those whom they have wronged. They will tell you with deep feeling that there is no such thing as true professional courtesy apart from considerations of policy. That medical practice, as a business, cannot be successfully conducted on the principles of the highest morality. That to succeed in making a livelihood out of it a man must look upon it as a "game of grab."

We hold that the true conception of medical relationship is that of co-operation. The profession is one of the great guilds of mankind, to which are entrusted great and important interests of the race. These interests are so vital that members attain maturity, and are, as a rule, fully trusted by the community, only when they have reached or passed middle life; consequently the first part of the pathway to success is usually more difficult than in other callings. It is very desirable that a new member should from the first exhibit toward his fellows such friendliness as to gain the confidence of his seniors who hold the confidence of the public. By and by these will have attained a sufficiency, or will have passed the age of great activity and efficiency, and will be glad to have younger associates to whom they may entrust the more arduous tasks in which they formerly delighted.

Patience is needed—patience which, as Lowell says, "is the *passion* of great hearts;" and industry, which has no place for rust and dissipation; and courtesy, which is the sure foundation of friendship. Time does the rest.

PUBLISH YOUR OWN EXPERIENCE.

In looking over the pages of the large American medical journals one is impressed with the fact that the articles in them are written by a few men; the great mass of practitioners being conspicuous only by their silence. The natural conclusion would be that the experience and thought of the great body of practitioners is not of any value to their fellows; or else that they are stored up in the mind of the owner in such a confused mass that they could not be easily written out in orderly statement. Yet we know that many of these silent brethren are men of good education, keen insight, well-balanced judgment, and excellent therapeutic skill; men who in ordinary conversation or in professional consultation express their views clearly, concisely and forcibly.

The trouble arises not from their inability to contribute to the permanent stock of the profession's knowledge, but rather their wrong conceptions of what is to be expected in such contributions. They suppose that their writings must either contain information not yet made known in print, or else embody the results of long and thorough research into its literature. Being debarred, by the inaccessibility of libraries or by the absorption of daily duties, from the reading which they deem necessary, they keep their thoughts to themselves and let other men, perhaps far less capable, occupy the attention of the medical public.

In reality this public demands abstruse disquisitions only from literary workers of small practice; and it is not by any means necessary that an import-

ant thought or fact should never be brought out anew before the attention of practitioners. Let the observer of experience and reflection but write down his thoughts or observations in a simple and straightforward manner and the profession will always be ready to give him attention.

Diseases vary in symptoms in different localities, and need in one place modification of treatment bestowed in other places. Diseases, too, change with the age of the world, and need new remedies as generations pass away. All diseases have not yet been defined and fully described. New diseases arise, and these need study and description. Old drugs are but incompletely understood. The text-book writers have frowned upon some old remedies which are of value and call for champions. Many valuable discoveries and combinations perish with the death of the discoverer. New remedies are still lying hid in the vegetable world awaiting honest research.

There rests therefore upon every thoughtful physician an obligation to put on permanent record some of the truths which have been revealed to him during his life-time of clinical observation.

Medical Progress.

ECLAMPSIA AND SEPTICÆMIA

Loviot (*Nour. Arch. d' Obstet. et de Gynec.*) describes a highly-complex labor where the patient was saved after extreme complications. She was a primipara, aged twenty-seven. Loviot found her in labor at term, and very badly nursed. The first twin presented at the breech; the forceps were applied and it was delivered. Then the patient was allowed to rest for an hour, the pains being very feeble in the meantime. The head presented, the membranes were ruptured, the forceps applied, and the child safely delivered. The twins were males and both alive; there were two placentæ. The patient's previous medical attendant had detected a great quantity of albumin in the urine. Antiseptic solutions were injected. Three hours later she had a fit. She was not treated with care; delirium set in, and when Loviot was called in, two days and a half after he had delivered the child, he found her temperature 105°, liquid motion pouring away from the bowel, and fœtid lochia discharging from the uterus. A large slough involved the vulva and a tract of the vagina. The slough was scraped away, several litres of solution of sublimate (twenty-five centigrammes to a litre of water) injected into the uterus, and the raw surfaces powdered with iodoform. The vagina was drained with iodoform gauze. The next day the curette was applied to the uterus, which was drained with the same dressing. At the end of third week there was slight phlebitis in the right leg, which lasted six days. The patient shortly afterward left for the country, her health being perfectly re-established, excepting that the urine contained a trace of albumin.—*Brit. Med. Jour.*

FLUIDS WITH FOOD.

There is a very common impression that fluids should not be taken with our meals—"they dilute the digestive solvents." Water, in some form, is as important at meal time as mastication, and it is as natural to take fluids with our food as it is to eat. They assist in both the separation and assimilation of its nutrient

elements. While they must not be taken in excess at meal time, or at any time, we must learn by observation what "excess" means. Learn your gauge, then "eat, drink and be merry."

CONDEMNATION OF TUBERCULOUS MEAT.

At a recent meeting of the British Medical Association, Dr. E. W. Hope said: Cattle, pigs, poultry, and rarely sheep, are all liable to be affected with tubercle, but it is in cattle, and more especially in milk cows, that tuberculosis is met with. The flesh of the tuberculous animal is affected in varying degrees, and much diversity of opinion exists as to the stage at which the flesh should be condemned. Opinion is practically unanimous that in advanced stages of tuberculosis the consumption of the flesh should be prohibited, not that every observer is prepared to state that its consumption would give rise to specific inoculation, but on the general grounds that the flesh is so deteriorated as to possess no longer the nature, quality and properties of wholesome nutritious meat. Thus far the position is a simple one, and any practical butcher can recognize when the disease has advanced so far as to prejudice the quality of meat. Tuberculosis is known by various names, such as "grapes," "wasting," "pearls," and the like, the first term being perhaps the commonest, from the fancied grape-like arrangement of nodular tuberculous masses frequently found adhering to the chest walls. The most common seats of the disease are the lungs, pleuræ, and other serous membranes; the liver, lymphatic, and other glands are often affected, sometimes the marrow and the nervous system, and it is also alleged that bacilli have been found in the flesh. The extent of the local lesions varies widely: they may be limited to a single nodule, or almost the entire organs mentioned may be invaded, their tissues destroyed by caseous or calcareous masses or by liquefying pultaceous matter. Grape-like aggregations of various sizes attached to serous membranes are extremely common, and the condition left by stripping them away with the costal pleuræ, with a view to conceal the appearance of disease, should at once attract attention and lead to a close examination. The various conditions are all forms of one and the same process, and caused by a microbe, which, growing in the tissues, gives rise to the tubercles, and which, by reason of it being thrown off from the diseased animal in quantity, renders the malady a contagious one. The temperature which is most favorable to the growth of the microbe is that of the ordinary body heat of a warm-blooded animal, say 98° to 100°F. A temperature of or below 32°F. appears to kill it, as does also continued exposure above 108°F. These are points of considerable practical moment, as suggestive of the probable effects of cooking or of refrigeration upon the bacillus. It is regarded as established that the infectious discharges of a tuberculous animal remain actively virulent in this climate for a long time after they have been cast from the body, and stalls and sheds may thus become a source of danger unless thoroughly cleansed. Inhalation appears to be the usual way in which the microbe enters the body, a circumstance which would be anticipated from the frequency with which the lungs are the seat of the disease; on introduction into the blood the disease may spread so rapidly as to constitute acute or general tuberculosis, or on the other hand it may be limited for a considerable time to the point of entry and neighboring lymphatic glands, which local lesions are frequently the only ones detectable, producing during life no symptom whatever, the animal being slaughtered in prime condition. As the malady progresses, emaciation and weakness become marked, milk diminishes and is poor in quality; when the animal is slaughtered the extensive signs of the disease already described are met with, the flesh is soft, skinny and dropsical, the fat wet and

flabby, the carcass, in short, presenting every sign of unsound meat. A very important and much discussed question is: At what stage is the flesh of a tuberculous animal unfit for human consumption? Some observers contend that the whole carcass should be destroyed if the merest trace of tubercle is discovered, even though the carcass may be otherwise in prime condition. The general practice, however, in this country is to condemn any carcass in which the disease is extensive, or has progressed so far as to cause deterioration of the flesh. In Prussia, where very great care is taken in inspecting meat, the law is to this effect: "The condition of the flesh of a tuberculous animal is to be regarded as dangerous to health when the meat contains tuberculous nodules, or the tuberculous animal has begun to show emaciation; while, on the other hand, the meat is to be regarded as fit for food when the masses of the tubercle only occur in an organ, and in general the beast is well nourished." The French decree says: "The flesh of the tuberculous animals shall be excluded from consumption (1) if the lesions are generalized, that is to say, not confined; (2) if the lesions, although localized, have invaded the greater part of an organ, or are by an eruption on the walls of the chest or the abdominal cavity." That the tubercle bacillus may be introduced into the body by swallowing is shown by the fact that tuberculous secretions, mucus, saliva, portions of tubercles from diseased tissues, and cultures of the bacilli have been swallowed by various animals, and some of these animals have subsequently developed the disease. It will be noted that in all of those cases the presence of the bacilli was demonstrable in the tissues swallowed—the most diseased parts were, in fact, carefully selected for the experiments. There is obviously a vast difference between eating masses of tuberculous matter and eating the properly cooked flesh of an animal which is sound except for the presence of, say, a nodule in the lung. In the report of the inquiry of the Departmental Commission appointed by the Privy Council in 1888 to inquire into the subject of tuberculosis, no case of tuberculosis in man from eating the flesh of tuberculous animals was stated, although witnesses were fully interrogated upon this point. Professor Bang, of Copenhagen, thinks that experiments show that the muscular tissue is so unfavorable a nidus for the tubercle bacilli they do not multiply in it. He is of the opinion that the seizure of the meat of every tuberculous animal is too severe a measure, and where the lesion is localized he does not consider that the consumption of the meat is attended with danger.

THE INFLUENCE OF PARTURIENT LESIONS OF THE UTERUS AND VAGINA IN THE CAUSATION OF PUERPERAL INSANITY.

Four cases were reported, in each of which there were rupture of the perineum, laceration of the cervix, and morbid conditions of the ovaries and tubes. In all laparotomy was performed and the uterine appendages removed. Two of the cases, one of ten weeks' and the other of eighteen months' duration, recovered their normal mental condition after the operation. The other two cases, both of five years' duration, and in a condition of partial dementia, were very much improved.

These cases are held to justify the following conclusions:

1. Puerperal insanity is, in at least the majority of cases, an infection psychosis.

2. Without rejecting the influence of other factors, such as heredity, anæmia, exhaustion, mental shock and distress, careful observation will show that few cases of puerperal insanity occur without preceding, or coincident, puerperal infection.

The reasons for this opinion may be briefly summed up as follows:

Puerperal insanity occurs in the great majority of cases within the first ten days after delivery—about one-half in the first five days—the same period during which puerperal infection usually occurs.

2. It is usually accompanied by elevation of temperature and other evidences of febrile disturbance.

The clinical form in which puerperal insanity manifests itself is, in the majority of cases, that of acute delirious or confusional mania. Depressive states are rare, except as secondary forms. In other words, the most frequent condition is one most closely resembling febrile delirium.

4. The death-rate is much higher than in simple mania. Death occurs from exhaustion, usually with high temperature and rapid pulse.

5. Post-mortem examinations, though apparently infrequent in these cases, have shown grave involvement of the pelvic viscera.

6. Examinations of the pelvic organs during life show lacerations of the perineum and cervix uteri (facile channels of infection in the puerperal woman). As secondary conditions are found intra-pelvic (peritoneal) inflammations, and consequent abnormal locations, fixations and congestions of the uterus, tubes and ovaries.

7. The results of operations seem to show that removal of local sources of irritation increases the chances of recovery from the mental disease.—*Times and Register.*

SURGERY OF THE THORAX.

I imagine that the surgical treatment of pleural effusions, whether serous or puriform, has been so far advanced during the last ten or twelve years that certain formulæ may now be admitted: (1) that early evacuation is the best principle to act upon: (2) that the exclusion of air where practicable and the observance of aseptic or antiseptic *technique* should be rigidly observed: (3) that complete and perfect drainage of the cavity under treatment is essential, including counter-openings and large openings into the pleura or other pus-holding cavities: (4) that large cavities require adequately large openings: (5) that ribs and periosteum, intercostal vessels and nerves may be largely excised with advantage immediate and prospective, so long as ordinary precautions are observed: (6) that lack of early and adequate operations are important causes, though not the exclusive causes, of delay in the closing of cavities: (7) that lung abscesses and gangrenes and bronchiectatic cavities, with certain obvious exceptions, are amenable to surgical exploration and treatment: (8) that hydatid cysts in the lung or pleura may be successfully extracted or otherwise cured by thoracotomy. It will not be safe, at the present stage of our experience, to extend these formulæ. They reach as far as amenable cases go, but there remain to be mentioned those instances of disease and difficulty which are found to baffle the physician, whose province it is to define the disease and its locality, and the surgeon, whose province it is to bring surgery to assist medicine.

1. Difficulty of diagnosis, which may cause the physician to delay surgical assistance; for instance, the defining remote, small, pleural effusions and lung abscesses. 2. Procrastination for other reasons. For the latter one can offer no excuse, but for the former difficulty a surgeon can offer this amount of assistance—namely, repetition of exploratory incisions and punctures. 3. When a large cavity is placed under the scapula. 4. When an enormous pleural cavity is bounded on one side by a collapsed, movable, swinging, dangling lung, and on the other side by a rigid bony wall.

This is a most formidable difficulty to overcome, and particularly when there is little or no disposition to the formation of granulation or cicatricial tissue. Sponge grafting has failed. Abstraction from the wall of the chest of a great portion of its bony rigidity does not necessarily succeed. This is a condition of things upon which we may hope that the discussion of this meeting will throw some light.

I would ask in this connection this question, Would the removal of the useless swinging lung, at or near its root, be a safe and useful measure? I am disposed to think that its presence is an obstacle to the cessation of discharge from the pleura, and that its removal would be a step half way to cure. I am supposing that the lung is useless as a respiratory organ, and that adequate measures for its fixation have failed of their purpose. The loss of such a spoiled organ should prove to be a gain.

There are two other conditions remaining to be mentioned—namely, tuberculous cavities associated with other tuberculous deposits and multiple bronchiectatic cavities. These, up to the present time, have proved insurmountable diseases and difficulties.—John Croft, F. R. C. S., British Medical Association.

ELECTRICITY IN GASTRALGIA.

Electricity enables us not infrequently to diagnosticate between gastralgia dependent upon organic changes in the stomach, such as ulcer, beginning carcinoma, etc., and gastralgia of the purely neurotic type. A case in point occurs to me. Some time ago I was consulted by a gentleman for a severe pain in the stomach, that had persisted for more than six months. The character of the pain was suspicious, and he had been told that the cause of it was ulceration. As in pain from that cause, so the pain in his case was referred to one spot in the epigastrium and in the back. When the stomach was empty, but little, if any, pain was experienced; but in a very few moments after eating, the distress was often extreme. The first application of electricity was made at the beginning of a severe paroxysm of pain, and within five minutes it disappeared completely. This result indicated very clearly to my mind that we were not dealing with an ulcer, for in a number of cases of this character which have fallen under my observation, every one had failed to be relieved by any form of current or any method of application.

It is not to be expected that this aid to differential diagnosis never fails, for true gastric neuralgia may resist the action of the current, as do other neuralgic types. When, however, it does relieve as promptly as in the case just referred to, its diagnostic value is undoubted.

In treating gastralgia both forms of dynamic electricity have proved effectual, and in the selection of the current, one must be governed by the special indications in each individual case. Not infrequently indeed, it will be found impossible to determine which form of current is best adapted to the case in hand until actual trial is made. In a considerable experience, however, in the treatment of gastralgia, I have found that in those cases where firm pressure over the seat of pain tended to relieve rather than to increase the pain, the faradic current of high tension, or the rapidly interrupted static induction, current yielded the best results. On the contrary, when the part was sensitive to pressure, pain being increased rather than relieved, the galvanic current generally proved most effective. In one case of gastralgia in which the faradic current of high tension was indicated, but which failed to accomplish very much, the static interrupted current succeeded in affording speedy relief.

In using the galvanic current, I prefer electrodes of plastic sculptors' clay,

placing the anode over the seat of pain. In this way currents of twenty to thirty milliampères, through a comparatively small electrode, are easily endured.—Dr. A. D. Rockwell, *Boston Med. and Surg. Jour.*

THERAPEUTICS OF CONSTIPATION; NEW REMEDIES.

Dr. Acheson (*Canadian Practitioner*) divides the pathological states of constipation into three groups:

1. Conditions where there is deficient glandular secretion, as in various lesions of the liver, pancreas and mucous coat of the alimentary canal.

2. Conditions where there is deficient intestinal peristalsis, as in central or peripheral nervous diseases, and atony or degenerative changes in the muscular coat of the bowel.

3. Conditions where there is congenital or acquired mechanical obstruction, due either to structural modifications of the intestine itself, or to pressure resulting from some cause external to the intestine.

He then goes on to say that he will discuss treatment of the first two groups, and divides remedies under four heads: *a*, Mechano-therapy. *b*, Electro-therapy. *c*, Enemata. *d*, Drugs by the mouth.

1. Mechano-therapy includes general exercise, Swedish movements, and massage. Massage is applicable to the second pathological group, and especially for women with lax abdominal walls, the result of frequent pregnancies, constipation associated with obesity, and in that form which is found frequently in those who do not take enough exercise. In short, it is indicated in atony of intestine from whatever cause.

The effect of massage: *a*, It increases intestinal and other secretions. *b*, It stimulates intestinal peristalsis. *c*, It acts mechanically by pressing accumulating fæces towards the rectum. It should be employed daily, and for not longer than twenty minutes at a time, by a competent operator.

2. Electro-therapy.—Electricity is employed in cases due to general nervous disease, such as neurasthenia and chronic diseases of cord, also in cases where the stools are hard and dry after cathartics.

Millican advises strong faradication of the abdomen with a powerful coil, one pole being placed over the lower dorsal vertebra, the other passed in the direction of the colon, and generally over the whole abdomen.

Kollner advises electricity and massage combined, and prefers a weak current, as being less likely to paralyze nerves. The strength of the current should never be great enough to cause pain, and its application should not last for more than fifteen minutes at a sitting.

3. Enemata.—Glycerine is the principal agent. Nothing but chemically pure glycerine should be used. Other enemata have been used, as yeast in small quantities, and an infusion of tobacco, one drachm to the pint, half of this quantity being injected at once. Another drug that has been lately recommended by Flatean is boracic acid in powder, applied by insufflation to the mucous membrane of the rectum in doses of forty-five grains. It is serviceable in torpor of the colon, and causes strong peristalsis in from one to three hours.

4. Drugs by mouth.—Hydrastis in five-drop doses of the tincture given in water night and morning for chronic cases. Collinsonia canadensis as fluid extract in doses of two to ten minims, or as tincture in doses of five to thirty minims. Cascara sagrada is especially beneficial in chronic cases where digestive powers are weak, and one great advantage it has is that there are no secondary constipating effects. The dose is five to thirty drops of the fluid extract from two to four times a day.

THE FIRST HOSPITAL IN MONTREAL.

The history of the first hospital built in Montreal, as told by W. H. Kingston, before the British Medical Association, is as follows:

The first hospital—the Hotel Dieu—is the outcome of female love and heroism. The history of the latter is so strange, so unique, that I may be pardoned if I allude to it at length. When Jacques Cartier returned to France, after his discovery of Canada, the news of his exploit travelled over France as quickly as was then possible. A French girl, described as young and beautiful, became impressed with the thought that the newly-found country should be the scene of her labors. She succeeded, after a time, in fitting out a small barque, with money furnished by a Madame Bullion, and, with twelve sailors, crossed the Atlantic in the spring of 1641. The sea voyage to Quebec occupied three months —it can now be accomplished in one-fifteenth of that time. The journey from Quebec to Montreal by the St. Lawrence, which can now be performed in a night, then occupied eight days. Miss Mance's barque came to anchor at a projecting point off the island of Montreal, then called Hochelaga. Hochelaga was, at that time, the *chefliew* of the war-like Hurons. They looked with amazement at the advent of pale-faced men and *one* pale-faced woman—for she was alone of her sex. They soon recovered from their surprise, however, and it was necessary for the colonists to throw up for their protection, as quickly as possible, wooden palisades on the land or rear approach; the big canoe, as the barque was styled, was a sufficiently imposing defence in front. If a colonist ventured beyond the palisades to gather fruit and berries, or to cut wood, he ran the risk of being pierced with arrows. Half of the first colonists perished in this manner, and Miss Mance was obliged to return to France in 1649, bringing back with her other recruits; and again in 1658, leaving France with twenty male and female recruits, half of whom died on the voyage of a form of plague. In their attacks on this small force some of the red men were wounded in return, and, when deserted by their comrades, they were brought within the palisades to what they and their tribe considered certain death—according to their own custom in warfare. They soon found the hospital to be a place of woman's tenderest solicitude. When the red man's wounds were healed a repast of dog's meat was prepared for him, and he was permitted to rejoin his tribe to tell what the pale-faced maiden had done for him. It need not surprise us to be told that in the presence of such devotion the warlike Huron soon forgot his ferocity.

A few years later it was necessary for the small colony to move a few hundred yards inland. Word went throughout the Huron Camp, and, before the hour of departure, the aborigines had strewn the ground with leaves and the branches of trees and with wild flowers, saying the earth was not fit to receive the tread of these women. In this way our first hospital was established, and in this way the light of Christianity was brought to the island of Montreal. Here is how the hospital has been sustained. Miss Mance had obtained from the French King a deed of gift in perpetuity of the small piece of land where she had landed, which, at that time, was valueless. It became, however, in the course of years, the centre of the village of Montreal, and eventually the commercial city clustered around it. A century and a third ago, when Canada passed from the rule of France to that of Great Britain, respect was paid by the conquerer to the rights originally conferred by the French King, and the hospital, which at first had but the aborigines for inmates, continued to receive within its walls, as colonization went on, persons of every succeeding nationality. For upwards of a hundred and fifty years after its foundation, it alone afforded asylum to the sick and

wounded of Montreal and westward. How many from these shores, when sick and disabled, have there received maternal care! How many of your children, in that then far-off land, had the pillow of death smoothed for them there, and without fee or pecuniary reward! And the same continues to this day; for the property preserved to those religious ladies by a wise conqueror, has, without municipal aid or Governmental patronage, but with economy, sufficed for the wants of the institution.—*Brit. Med. Jour.*

NITRO-GLYCERINE IN NEPHRITIS.

Dr. Geo. L. Peabody, Practitioners' Society of New York, relates the following cases: A blacksmith, sixty years of age, who had marked diffuse nephritis, mitral insufficiency, and general thickening of all the superficial arteries. The renal history and the cardiac history extended over four or five years. The urine was always abundant, always contained granular casts and albumin, and the pulse was always of high tension until he was put upon nitro-glycerine. On January 12th he was given one-hundredth grain of nitro-glycerine every four hours. It was rapidly increased until, in February, he was receiving a grain every two hours, or twelve grains in the twenty-four hours. By February 21st he received two grains every two hours. It was only under two grains every two hours, day and night, that dyspnœa disappeared, the strength increased, and he was able to go out of his ward. He improved so much that he insisted on going to his daughter's, in Buffalo, and in order to enable him to undertake that journey without receiving such large doses of nitro-glycerine when not under observation, the dose was gradually diminished. He left in March, while taking two grains every four hours. There had been absolutely no unpleasant symptoms attending the use of the drug, but very decidedly beneficial effects. He afterward learned that at Rochester the man became so ill that he was taken to a hospital, where he was recognized by one under whose care, as house physician, he had been in New York. This gentleman spoke of the large doses of nitro-glycerine which he had been receiving in New York, but the hospital physicians were so horrified that they allowed him to renew them only on his own responsibility. The second day sufficient amount of the drug was obtained and improvement followed at once upon its use.

The second case was one of Bright's disease under his care in the New York Hospital, with pulse of very high tension, occasional attacks of profuse and painful vomiting. The patient said that for two years he had suffered from vomiting before rising from bed in the morning; was then able to get up but could not work. There was hypertrophy of the left ventricle. About November 1st he began giving one one-hundredth of a grain of nitro-glycerine, gradually increased the dose, until he was receiving by the end of the month one-fifth of a grain every hour. On January 1st he received half a grain every three hours, then half a grain every two hours, then a grain every three hours, day and night, for several weeeks. The pulse improved in tension very much, but occasionally it would return to its original tension and then he would have attacks of persistent vomiting, lasting perhaps three days, and controlled only by enormous doses of morphine administered hypodermatically. During the vomiting attacks the nitro-glycerine was administered in the same doses subcutaneously.—*Medical Record.*

MALARIA IN ITALY.

Our readers will doubtless welcome statistics in regard to this bug-bear of travelers. In a recent editorial the *Lancet* says:

The prospect of the International Medical Congress of 1893, in Rome, is likely to direct the attention of the medical world in an unusual degree to Italy during the next twelve months. A brief survey of the condition of that country with regard to the prevalence of one of its chief scourges—malaria—as revealed by the most recent official information, will not be without interest to our readers. The present generation of medical men are apt to forget that time was, and not so very long ago, when ague pressed heavily upon the population of these islands and formed one of the most serious items in the annual bills of mortality. The progress of agriculture, the drainage of marsh lands, the general elevation of the average standard of comfort among us, have done much to banish it; but there are still districts which are, at least by comparison, distinctly productive of ague, such as Huntingdon, Cambridgeshire, and parts of Kent and Surrey. In the main, however, the improvement in this respect in the British Islands is most notable, and no doubt many medical men in different parts of these islands pass many years of active practice without once seeing a case of indigenous malaria.

Very different is the state of Italy, which ranks among the countries in Europe in which ague is most prevalent. The deaths from malaria in that country amounted (according to Dr. Davidson) in one year—viz., 1887—to 21,033, which would give the very high rate of 700 per million living. When we point out that this is only slightly below the mortality which scarlet fever causes amongst ourselves, it will be seen how important a *rôle* malaria plays in the pathology of Italy. The prevalence of the disease varies greatly in different localities and at different periods of the year. According to the authority just referred to, the most malarial districts are Basilicata (the region just north of the Gulf of Taranto), Calabria, Sardinia, Apulia and Latium, while the disease is less prevalent in the districts of Liguria, the Marches, Tuscany, Lombardy, Umbria and Piedmont. The variations are notable. Thus Basilicata shows a proportion of 822 deaths from malaria to 10,000 deaths from all causes; Latium, a proportion of 490; while the rate falls to 52 in Tuscany, 38 in Lombardy, and 7 in Liguria. This last figure is very reassuring to the vast numbers of invalids and tourists who annually seek health and relaxation in the Riviera and along the beautiful shores of the Gulf of Genoa.

The rates of mortality from malaria in the various Italian towns bring out many interesting facts. Rome indisputably takes the first place of all the large cities. The rate there is about 12 deaths from malaria per 10,000 of the population, which compares very unfavorably with the rate of 5 in Messina, 1·9 in Palermo, 1·2 in Milan, 0·9 in Venice and Naples, 0·2 in Florence, and 0·1 in Genoa. We were scarcely prepared to find the bad pre eminence of Roma so decided, or for the remarkable good place taken by Venice, Naples, Milan, Florence and Genoa. It will be seen from these figures that temperature alone will not account for the varying degrees of mortality from malaria, although on the whole the northern parts of the country suffer much less than the southern. We can imagine few more interesting problems in geographical pathology than the working out of the causes of this disparity.

NOTE ON DIASTASIS THROUGH NECK OF FEMUR.

In an article in the *Lancet*, August 20th, Dr. David Wallace writes:

Diastasis through the neck of the femur is described as a rare injury in our text-books, and Dr. Hamilton refers to only three problematical examples. In the "Archives of Surgery" the author refers to the detachment of the upper epiphysis of the femur, and specially directs attention to its absence from museum

collections, no specimen being extant, and he also refers to the rarity of any clinical descriptions of the injury. Mr. Hutchinson, however, states that he is "confident that it is an accident which is not infrequent." In the first week of April of this year, a few days before I saw Mr. Hutchinson's account of this injury, one of my students asked me to see a case of supposed old-standing dislocation of the hip. On examination of the patient I concluded that it was probably a diastasis through the neck of the femur, not a dislocation at the hip-joint. The history and condition were as follows:

M. B.—, aged eleven years, a girl of good build, tall and strong for her age, was said by her mother to have been a well-nourished child, who walked before she was nine months old. When nine months of age she fell out of her cot, and the mother believes that when falling the right foot caught between the bars, so that the leg was severely twisted. The child cried, and refused to stand up or allow the leg to be moved. There was pain and swelling in the neighborhood of the hip. Hot fomentations were applied during the first few days, but in the course of two or three weeks (?) a doctor was called in, who said the hip-joint was dislocated, and attempted to reduce it, but failed to do so. Two or three years later the child walked with a distinct halt, and the hip was prominent. At this time the mother showed the girl to a "bonesetter," who tried to put the bone in, but also failed. The swelling and lameless have persisted until now, but the girl walks, runs, and jumps without any pain, as a general rule, although after much romping she now and then complains of pain at the hip. No other injury has been sustained, and there is no history of joint or chest disease in the patient or in other members of the family.

Present state.—The patient complains of no pain or discomfort, but says she is lame and that the "leg comes out at the haunch." She walks with a distinct limp, and when she stands the right foot is observed to be a little more everted than the left, while there are marked drooping and rotation forwards of the right anterior superior iliac spine. The right limb is evidently shorter than the left.

Measurements.—1. From anterior superior iliac spine to internal malleolus: right, 27 in.; left, 29¾ in. 2. From anterior superior iliac spine to tip of patella: right, 14 in.; left, 16 in. 3. From tip of trochanter major to external condyle: right, 13¾ in.; left, 14¼ in. Nelaton's line on the right side passes 1½ in. below the tip of the trochanter; on the left side it is normal.

Movements.—The right thigh can be flexed on the abdomen, but not quite so fully as the left. Rotation of the right is greater than the left. Abduction is equal on both sides. When the right leg is flexed on the thigh and the thigh on the abdomen the trochanter major is felt as a distinct prominence midway between the anterior superior spine of the ilium and the ischial tuberosity, and moves through a much wider radius than the left. No rounded prominence corresponding to the head of the femur can be felt, but there is a distinct mass of bone projecting internally to the trochanter, which moves with the trochanter. (Is it the atrophied head of the femur in an old-standing dislocation, or a short process representing the neck thickened by osteophytes?) When rotary movements are carried out a rough grating is felt deeply seated. The right leg is thinner than the left, but is muscular and shows no sign of malnutrition.

From a consideration of the above points to this case I conclude that it is a diastasis of the neck of the femur, chiefly because of—(1) a history of injury at an early age, but subsequently to the child walking; (2) no history or appearance of tuberculous disease; (3) marked displacement of the trochanter major upwards,

associated with very free movement and eversion of the foot; and (4) a slight degree of shortening of the femur.

REPORT OF FRENCH COMMISSION ON CHOLERA.

Notes extracted from report of French commission on cholera (*La Progres Medicale*) gives the treatment as follows: 1. To stimulate the patient with hot drinks and applications.

2. To arrest the diarrhœa with the following draught: Lactic acid, 10 grms.; syrup, 90 grms.; alcoholate of lemon, 2 grms.; water, 1 litre. Dose, three tablespoonfuls every quarter hour.

For the vomiting, pieces of ice, aërated waters. If menthol were more manageable, Dujardin-Beaumetz would give it the preference. As to opiates, he extols, above all others, the paregoric elixir of the N. Y. and B. formulary, modified by Goblet. Constantin Paul called attention to the fact that cholera patients do not eliminate, and, therefore, caution should be observed in the use of poisonous drugs. Vigier considers the superiority of paregoric elixir due to the antiseptic benzoic acid and camphor which it contains. Beaumetz referred to menthol, and said that by it ipecac may be administered in high doses in dysentery, without causing vomiting. Paul explained the inefficacy of bismuth in cholera by the fact that the drug only acts on the large intestine. Lactic acid, on the contrary, produces its effects in the small intestine, and that is where the bacillus must be attacked.—*Times and Register.*

Medical Items.

A chair of Chemistry of Foodstuffs has been established in the Munster Academy.

The proportion of venereal disease in the Italian army for the year 1890 was 30 per 1000.

The Starling and Columbus Medical Colleges, of Columbus, Ohio, have lately united.

The cable brings report of unusually hot weather all over Europe, and many cases of sunstroke have occurred in the large cities, and among the troops who have been forced to perform their ordinary evolutions under a mid-day sun.

The digestibility of various kinds of cheese has been recently tested by a German chemist, who placed the samples in fresh gastric juice. Cheshire and Roquefort cheese took four hours to digest; Gorgonzola and Neufchatel, eight hours; and Brie and Swiss cheese, ten hours.

The Association of Hospital Physicians and Surgeons, of Philadelphia, has been organized to afford physicians, who visit the city and desire to stay to take advantage of the clinical facilities of the various hospitals, an opportunity to witness practical work in any line of general or special medicine or surgery in which they may be interested.

Huguin (*Medec. Med.*, July 2, 1892) thinks that photophobia, with dilatation of the pupils, is a preliminary sign of pertussis. By means of this sign he has been able to diagnose pertussis before the characteristic whoop. Increase of lachrymation and conjunctivitis have already been described as preceding the attack.—*Annals of Gynæcology and Pædiatry.*

We regret to learn that Dr. John C. Sundberg has resigned from the editorship of the *Pacific Medical Journal*, where he has waged untiring warfare with

evil in public and private medical life, and has nobly upheld the standard of right and truth. His place will be taken by his former co-editor, Dr. Winslow Anderson. The address of the *Pacific Medical Journal* is changed to 603 Sutter Street, San Francisco.

At a meeting of the Society for the Study of Inebriety, held at the rooms of the Medical Society of London, on July 5th, the former society resolved that "this meeting having been informed by a competent London analyst, who made a special analysis, that the alleged 'bichloride of gold cure' shows no trace of gold or chlorides, and contains 27.55 per cent. of alcohol, condemns unreservedly the prescription of such an intoxicating preparation to an inebriate."

Drs. Acosta and Rossi, of Havana, have made a series of examinations of the paper money issued by the Bank of Spain, which is current in Cuba. Every one who has been in Havana will remember the filthy condition of the small denominations of bills, especially those representing but a few cents. Two of these notes contained more that 19,000 germs of various kinds. Cultures were made on different media, and injected into the peritoneal cavity of rabbits and guinea-pigs, most of which died within twenty-four hours.—*Boston Med. and Surg. Jour.*

Experience has taught our poor nothing regarding the simplest laws of health and disease. The sick man or child or mother lies moping in a dirty bed, or bowed in misery in the corner of a steaming hot room without ventilation, utterly without proper care, receiving at the utmost an occasional dose of drugs prescribed by the neighboring doctor or druggist. Medical man as I am, I do not hesitate to say that medicine under these circumstances is mockery, and it would be better literally to cast the physic to the dogs, and in its place let in a little fresh air and sunshine. The visits of the district nurse are literally life-giving, and she departs from each of her ministrations leaving a brighter, happier, more hopeful patient behind, eagerly anticipating the following visit.—Dr. Kelly, in address to Johns Hopkins nurses.

The graduates and students of Jefferson Medical college, and the profession at large, will regret to learn that Professor J. M. DaCosta, who last year resigned the Professorship of Practice of Medicine, will no longer take part in the clinics of that institution, having retired from all teaching in connection with it. No lecturer was ever more popular, or held in greater esteem by those who were so fortunate as to receive the benefit of his instruction, and among these may be included not only his immediate class, but the general profession, who were occasionally, but much too seldom, offered an opportunity of reading his clinical teachings as reported in the medical journals.—*College and Clinical Record.*

A married lady, whose monthly flow was scant and irregular, was advised to take an "Electric" bath, and went for that purpose to an establishment which is not under medical supervision. The woman in attendance placed one electrode in the vagina and the other on the outside above the pubis. The lady asked: "Would this hurt me if I should be pregnant?" She was assured that it would not, and that many physicians sent their wives there for similar treatment. Two weeks later she aborted, the fœtus indicating four months' pregnancy. It might be well for the grand jury to investigate all such institutions which are conducted by irresponsible persons, and when physicians have occasion to recommend Hammam or electric baths, they should send them to some establishment under charge of a skilful and conscientious physician.—*Pacific Medical Journal.*

Dr. Lauder Brunton, in a recent address, laid great emphasis on the necessity

of care in diagnosis, and gave some amusing instances of errors in this important part of a physician's work, due to too hastily formed opinions. In one case he was among a class of students around a man suffering from heart disease, when it was noticed that the pupil of one eye was much more dilated than the other. At once numerous more or less learned suggestions were made to account for the mydriasis. Eventually the man informed them that the eye over which there had been so much animated debate was a glass one. Another instance related to a learned professor who used to boast that he could tell much concerning the medical history of his patients by their teeth. When holding forth on his favorite theory one day he was considerably disconcerted by the patient taking out the complete set of masticators, and saying: "Perhaps the gentlemen would like to look at them closer."—*College and Clinical Record.*

Mr. Robert A. Barnes, who recently died in St. Louis, left provision in his will for the erection and endowment of a hospital to bear his name and to be under the control and management of the Methodist Church. The gift amounted to more than a million dollars. During the sixty-two years that he resided in St. Louis, Mr. Barnes contributed largely to many charitable and educational institutions. He is credited with having built no fewer than fifteen churches in the southern part of Missouri. As an expression of appreciation and as an honor to the memory of Mr. Barnes, those having in view the origination of a new medical college named it the Barnes Medical College. Among the faculty are Dr. C. H. Hughes, Dr. A. M. Carpenter, Dr. J. T. Jelks, Dr. William Dickinson, Dr. J. W. Vaughan, Dr. Pinckney French, Dr. Frank D. Wright, and Dr. S. C. Martin.—*Pacific Medical Journal.*

The Union Medical Association of Pennsylvania and Maryland met at Happy Valley Thursday. The meeting was called to order at 12 M., by Dr. Virdin, of Lapidum. Dr. A. C. Crothers, of Port Deposit, delivered the address of welcome, which was replied to by Dr. Frye. Short addresses were then delivered by Drs. Craig, Ulrich, Buckley, Morris and Zeigler. The deaths of Dr. Joshua Beaver, of Lancaster County, and Dr. William Forward, of Harford County, were announced and resolutions of respect were adopted for each. The nomination and election of officers for the ensuing term resulted as follows: Dr. John Morris, of Baltimore, president; Dr. Gable, of York, vice-president; Dr. Bucher, of Lebanon, Pa., second vice-president; Dr. Livingtone, of Columbia, secretary and treasurer. Dinner was served. The meeting was again called to order and more resolutions were read, after which the convention adjourned until their next annual meeting.

We are informed that our friend Dr. Wm. B. Canfield, the well-known author, and former editor of this JOURNAL, has now *in press*, to be issued during the present month, September, a work of about 250 pages, entitled "The Hygiene of the Sick-Room;" a book for nurses and others, being a brief consideration of asepsis, disinfection, bacteriology, immunity, heating and ventilation, and kindred subjects, for the use of nurses and other intelligent women. By Wm. Buckingham Canfield, A. M., M. D., lecturer on clinical medicine, and chief of chest clinic, University of Maryland, visiting physician to Bay View Hospital, etc. 12mo., cloth. The publisher is P. Blakiston & Co., 1012 Walnut Street, Philadelphia. To those who desire to bespeak copies we may say that the address of Dr. Canfield is 1010 N. Charles Street, Baltimore. We will present to our readers a careful review of the volume at the earliest opportunity after publication.

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CONTENTS

ORIGINAL ARTICLES.

Diagnosis of Acute Intestinal Obstruction: with Cases and Autopsy Reports. By J. Fussell Martenet, M. D. With Case Added. By Wm. T. Watson, M. D. 991

Notes from Leopold's Clinic. No. II.—Podalic Version. By W. S. Gardner, M. D., Baltimore. 998

EDITORIAL.

Vacation Notes. 1000

Electrocution in New York. . . . 1001

Requirements of Candidates for Army Medical Positions. 1001

The Board of Medical Examiners for Maryland. 1002

REVIEWS, BOOKS AND PAMPHLETS. . . . 1003

MEDICAL PROGRESS.

Typhoid Fever.—On Certain Diuretic Drugs.—The Radical Cure of Inguinal Hernia in Children.—Cerebral Surgery.—Sleeplessness.—Chimney Sweep's Cancer.—Congenital Contraction of the Colon.—Hæmorrhage After Tonsillotomy. 1003

THERAPEUTIC RECOMMENDATIONS. . . . 1011

MEDICAL ITEMS. 1011

Original Articles.

DIAGNOSIS OF ACUTE INTESTINAL OBSTRUCTION; WITH CASES AND AUTOPSY REPORTS.*

BY J. FUSSELL MARTENET, M. D.,

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WITH CASE ADDED.

BY WILLIAM T. WATSON, M. D.,

Clinical Assistant Children's Department and Woman's Medical College Dispensary.

There are many ways in which obstructions of the intestinal canal may be classified.

The first which may be mentioned is the *congenital*, which may be defined as a condition of occlusion of the lumen of the intestinal canal, in one or other of its parts, by its non-development, or by abdominal growths beginning during intra-uterine life, and which develop to such an extent as to encroach upon its walls and occlude its lumen, thus producing mechanical interference. The other associate condition or classification would be the *acquired;* or that coming on after acquiring extra-uterine, or, more properly, natural life.

Congenital would be: Congenital stenosis; congenital deformities; upon Meckel's diverticulum; upon peritoneal bands: the results of intra-uterine peritonitis, etc.

*Read before the Medical and Surgical Society of Baltimore.

Acquired would be: Strictures following ulcerations, intussusception, volvulus, strangulation by bands produced by peritonitis, cases of obstruction by foreign bodies, and, indeed, all the principal examples of intestinal occlusion. There may be also another form of acquired, one in which the occlusion is brought about by mechanical pressure from without, as by tumors, or by strangulation, as by the pressure of the intestine into an opening, and its retention there, thus compressing its walls, as was the case mentioned in the title of this paper.

And again, for clinical use, they may be thus classified, viz.: Acute; subacute; chronic; chronic, ending in an acute form.

Collectively grouped, one would find the various causes as made out by Treves to be as follows, viz.: Strangulation by bands, as through apertures; volvulus; intussusception; stricture; obstruction by neoplasms; compression by tumors, etc., external to the bowel. Obstruction by gall-stones and foreign bodies. Obstruction by entero-liths. Obstruction by fæcal matter.

Each of these varieties might enter into a share of the discussion of this paper; but, as many are of the sub-acute and chronic type, terminating in an acute attack, it will not be within the scope of this paper; and I dismiss them without further mention, and confine myself to the acute type alone.

The three clinical conditions to which we may need to give our attention most frequently in practice may be safely described in one of the following forms, viz.:

1st. Long continued constipation, obstipation, impaction or occlusion by fæcal matter. 2nd. Intussusception. 3rd. By strangulation as per hernia.

The most constant symptoms which one will find present are vomiting, pain and failure to accomplish normal movements of the bowel; and, if not seen at an early period, varying in the time of occurrence, collapse. The significance of these symptoms may be explained as follows: Vomiting is not constantly present; it may precede the more pronounced conditions in the attack, and may be the first annoyance to attract the patient's notice; it may occur subsequent to the expression of pain, and it may not occur until later on in the condition; and it may even, exceptionally, not occur at all (as in intussusception), or, again, only when produced by medication.

It is explained by the peristaltic action (the rhythmic contractions of the bowel, which we recognize as the propelling force to the ingested food in the intestine), which is uninterrupted, unless met by some narrowing or obstruction in the canal, when the contents stop; there is an accumulation, and finally distension of a varied degree occurs, occasioned by the contents alone, or by gases forming, or by serous or bloody discharges taking place into the bowel. A wave of peristaltic movement passing along the intestine above the occlusion will tend to produce two distinct currents in the contents of the tube, instead of a single one in the direction of the rectum, as is the case in peristalsis under normal circumstances. In normal peristalsis, one of the movements is in the downward direction, and is that which concerns such of the contents as are in contact with the

walls of the intestines. The other is an axial movement, and is that which concerns the contents occupying the axial or central part of the lumen of the bowel. By a constant stroke of the outer or downward peristaltic current of the contents against the obstruction, there is a rebounding effect, which at first is weak, becoming stronger and engaging more of the confined—now liquid—mass at the resisting obstruction, which current increases the volume of the upward or anti-peristaltic movement, until it is of more force than the downward or normal; and we then have the anti-peristaltic to predominate; hence the uncontrollable vomiting. (This we may easily produce in irrigating the bowel of an infant, by using too much force or volume in the injection of the water, and when this is produced the child will usually die.) The stomach empties first, then the adjacent bowel—the duodenum and jejunum; and if the obstruction be lower down, the contents of the ileum, or even those of the colon, may be rejected, when they become fæcal or stercoraceous.

In intussusception the vomiting comes on late, is not so conspicuous, and is not usually excessive or distressing at first; becomes stercoraceous only very late in the attack, if at all; fluctuates much in character, and may be mostly periodical. This one may explain by the fact of the ability of the contents to still pass through the obstruction, which is not yet complete and resistant enough to bring about anti-peristalsis. Later on the obstruction becomes complete, and the vomiting is produced.

In strangulation vomiting is always present at the onset, and even prior to the immediate attack. This is explained by the fact that complete resistance is always present in the strangulated mass; and from the fact that anti-peristalsis has already been established. The same may be the case in appendal or troubles in the ileo-cæcal region. *Pain* is a constant symptom, though it may begin irregularly; but is present at some time of the attack. It is due in the first instance to lesions of the peritoneum, and afterward to injury to the intestinal wall itself, as a result of the strangulation, and finally to the tumultuous and irregular peristalsis of the walls, which brings about irregular and distorted contractions. Reflex action may be excited, which in turn would produce much increase in the effort of the bowel to empty itself above the obstruction. That, too, increases the pain, and we have the most intense degree of excitability in the part. The degree of pain depends entirely upon the manner of the onset, and the increase or decrease in the character of the subsequent inflammatory lesions. The expression of pain depends entirely upon the excitability and the degree of tolerance of the individual. There is also a feature in the character of the pain, since in complete obstruction the pain is constant, with periods of intensity, asserting itself with severity at the onset; while in incomplete, there will be periods of relief, at times even entirely intermitting; which, however, will become constant when the occlusion is complete, still not losing the periods of exacerbation.

Early in the stage of obstruction the pain is not increased upon pressure, but

will be later on, due to the increasing hyperæmia or the developing peritonitis in the parts. A sudden intensity of pain in a part would indicate a rupture of the intestine into the peritoneal cavity. A diminution of pain later in the attack would indicate a paralysis, with a decrease in the sensitiveness of the parts.

Constipation in all cases depends, of course, upon the fact that the lumen of the bowel is lessened, or even occluded. Then, again, it is brought about or controlled, because of a paralysis of the segment of the bowel below, thus making it unable to empty itself, which may be done, however, by the use of an enema.

In some conditions of acute obstruction, there may be a hyperæmic condition with a subsequent catarrhal secretion poured out into the intestine; it again producing what one would call "diarrhœal" movements just previous to the complete occlusion. This is especially noteworthy, and a marked feature of the intussusception form.

A relaxation of the bowel and involuntary emptying of it may occur just prior to and at the approach of death.

Collapse.—In this condition it is so marked that one can readily recognize it. It is severe, and one can safely say that it is continuous. Its sudden onset is due to the suddenness of the lesion produced upon the peritoneum and the intestinal walls. It is due to a profound impression upon the nerve centers, displaying itself mainly through the sympathetic centers, producing certain grave and violent vascular disturbances. This change manifests itself in the altered circulation in the extremities, which become cold and wet with sweat, with a small and thread-like, compressible pulse, due also to a lessened circulation in the vaso-motor area.

The degree of collapse depends upon the resistance and vital energies of the individual, the manner of invasion of the trouble, and finally upon the amount or extent of intestine or peritoneum involved.

The significance of this condition in the several conditions is as follows: In *chronic constipation, obstipation, or fæcal impaction,* there will at first increasing nausea manifest itself before any other condition, which continues to become more pronounced, lasting an indefinite length of time; and finally active vomiting will assert itself. Preceding this nausea, loss of appetite, malaise and headache will exist from the overpacked or overfilled bowel, which has become so filled as to interrupt all efforts at digestion, and which also at times has allowed enormous accumulations, as noted in the following cases which are on record, viz.: one of a case where the bowels failed to move for a period of 12 weeks, one of 15 weeks, one of 18 weeks, others of 7 months, 8 months, 8 months and 16 days, and 9 months.

One case is on record where 60 pounds of fæcal matter was removed from a person, and a Dr. Little records the death of an idiot, aged 34, who died of long-continued constipation, who had an enormous appetite and ate everything.

Upon post-mortem examination the transverse colon was found six inches in diameter, while the descending colon and sigmoid flexure formed a huge pouch measuring 20 by 12 inches. The walls of the sigmoid flexure were found to be from $\frac{1}{8}$ to $\frac{1}{2}$ an inch thick.

Acute Intussusception.

Sex and age.—More common in males. Occurs in most instances in the young, and in 50 per cent. of all cases under ten years of age.

Past history.—Not definite, but in a few rare cases there may be a previous history of such attacks, due probably to such an obstruction.

Mode of onset.—Sudden in 75 per cent. of all cases.

Local tenderness about this tumor is common.

Pain.—One of the first symptoms, apt to be severe from the first, to increase up to a certain degree, then subside. On the whole, not severe as the other forms. At first it is distinctly paroxysmal. It may be referred to and localized about the tumor of the intestines.

Vomiting does not appear so early as in the other varieties, and is usually not so severe; in 3 per cent. of the cases it was absent, in 95 per cent. it was among the earlier symptoms, while in the remaining it did not appear until much later, possibly until after the third day. It is also liable to great fluctuation, and may be absent a while and then reappear. In only 25 per cent. of the cases did it become feculent and then only after the fifth day.

Constipation.—Bowels do not move often, but absolute constipation is very rare. Constipation as a symptom is noted in only about 30 per cent. of all the cases. Diarrhœa is more usual and in 80 per cent. of cases the stools are bloody in character.

Collapse.—In more acute cases in the young it is very marked, but on the whole is less than the other classes.

Tenesmus is met with in the majority of cases, and is present often early.

Abdominal parieties are flaccid unless peritonitis be present.

Tympanites is rare except in cases associated with constipation.

Tumors of a definite character are met with in 50 per cent. and can usually be felt in the rectum.

Intestines are not visible.

Strangulation by bands, or through apertures.

This occurs in more than 35 per cent. of all varieties of the obstruction.

Sex and age.—More common in males than in females. Most common in the young adults, rare after forty.

Past history.—There is generally a definite history of trouble in about 60 per cent., and a history of a possible obstruction in about 12 per cent.

Mode of onset.—Sudden in over 70 per cent.

Pain.—Is earliest or one of the earliest of symptoms. Extremely severe, colicky, continuous and persistent. May become less as the case advances, and is oftentimes localized.

No local tenderness at first, which, however, may develop later. *Vomiting* appears early or may even precede pain; is a marked feature, being constant, copious and severe. It becomes stercoraceous in 60 per cent., this condition beginning about the fifth day, and it offers no relief.

Constipation is marked and is obstinate. Enemata may effect an emptying of the bowel, but it will be only of material below the obstruction. No discharge of blood.

Prostration is excessive. Often profound collapse, intense thirst, with diminished urine.

No tenesmus. Abdominal parietes soft and pliable, unless peritonitis has supervened.

As an illustration of the conditions, I shall herewith report two cases occurring the last few weeks in the practice of myself and my friend, Dr. W. T. Watson.

Case of Irreducible Hernia.—At 12.30 A. M., February 26th, 1892, was asked to see Mrs. W., æt. 56, white, married, housewife, who presented the following history and condition.

Is a multipara, has three children living; two died of phthisis, the last was just buried the day of the onset of this illness; was fatigued much from nursing him. Has a definite history of a hernia, but never needed to wear a truss. This illness began with increasing nausea, followed by active vomiting: at which time she had an acute pain announce itself in her right groin: was at the time constipated. Has been under the care of a physician, who did not recognize her trouble. Bowel has never acted, but there was an emptying of the lower bowel following the use of a large rectal enema. Vomiting became gradually, yet progressively, more intense, and has been stercoraceous since three days.

Patient is pulseless at the wrist, skin is cold, clammy, and wet with a profuse perspiration: tongue not dry nor coated: is intensely thirsty: temperature offered no indication of relief, and was not taken. Is dying, though mind is clear, and makes complaint of the intense pain and the vomiting.

Examination.—Chest indications negative, abdomen is enormously distended with a tympanitic resonance, and tender to the touch, and there is no tumor to be felt by palpating the abdomen, or examination per rectum. There is a more marked distension in the right femoral region, but owing to the great swelling of the part, nothing definite is felt.

Diagnosis of hernial obstruction was made, and as immediate failure was indicated, no treatment was instituted, death following in about one half-hour. Autopsy was made ten hours later by my friend, Dr. William T. Howard, Jr., with the following result: Intestines, stomach and small intestines enormously distended with gas, in condition of paralysis; are of a deep-red color: veins along the mesenteric border distended. Cæcum and colon small and contracted: also portions of the ileum below the constriction. In places deep hæmorrhagic injection of the parietal walls and peritoneum. Distension stops abruptly in the right inguinal region, where there is a right femoral hernia the size of a lemon.

On section of the mass, below the ring is seen to contain several folds of the ileum of darker than normal color; a few flakes of lymph and some yellow serum, no inflammation. Obstruction involves keiat of the ileum 200 cm. above the ileo-cæcal valve. Does not permit passage of fluid or gas; complete obstruction, and portion of ileum below this small and contracted.

As there were no other conditions found which are of any interest to this paper I shall decline to present them.

For a case of acute intussusception, I am greatly indebted to my friend, Dr. William T. Watson, in whose practice the case occurred, and who has so kindly furnished me with a report of it, which I now present.

Henry W. B—, aged four months, a plump, healthy infant. At 1 P. M., March 18, 1892, without any premonitory symptoms, had a small stool of almost pure blood. This was succeeded by similar stools every hour or so for twenty-two hours, when I first saw the case. The baby was pale and weak, pulse rapid, temperature 101.5. The stools became less frequent and more serous in character. Vomiting occurred only after 48 hours. It occurred three times; the matter vomited was greenish, bilious stuff, of small quantity, and not stercoraceous. The patient grew steadily weaker and died in three days and eight hours from initial symptom.

The abdominal viscera were removed sixteen hours after death by Dr. Martin and myself and taken to the Hopkins laboratory, where they were examined by Dr. William T. Howard, Jr., with the following results:

28 cm. above anus is an intussusception of colon, beginning about the hepatic flexure of the colon, 12 cm. in length, measured on the outside. This includes nearly the whole of the great omentum in such a manner as to pull the pyloric entrance of the stomach down to the entrance of the invagination. The invaginated portion includes the ascending colon, cæcum and lower portion of the ileum. Length of small intestine from entrance of invagination to pyloric end of the stomach is 275 cm. A few recent adhesions on surface of mass and between the omentum and the gut. By gentle traction the mass can be reduced up to a certain distance, after which the constriction is impassable and folds of gut and the mesentery seem to be densely adherent inside. Included in the invaginated mass there is a small, hard body, the shape of a lymph gland, dark-red on section, measuring 18 by 4 by 3 mm. The small intestine inside the mass is dark-red, deeply injected, not gangrenous. Above the point of invagination the gut is greatly distended, containing a large amount of yellow liquid fæces of normal odor. For 50 cm. above invagination there is injection of intestine along its mesenteric border and here and there small areas covered with fibrin. Gut above this is pale. Below invagination gut is empty. The other viscera are normal.

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NOTES FROM LEOPOLD'S CLINIC.
NO. II.—PODALIC VERSION.

BY WILLIAM S. GARDNER, M. D.,
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The examination and preparation of this patient before being brought into the confinement room were just the same as that given in detail in my previous communication; and to save repetition they will be omitted now. The antiseptic precautions here detailed were used in addition to the ordinary ones used in simple normal labors.

By external examination it was known that the child was in a transverse position, with the right shoulder presenting, the head toward the left side and the back forwards. The indication for active operative measures was the rupture of the bag of waters. The steps of the operation will be given as nearly as possible in the order of their occurrence.

The operator and two assistants washed their hands vigorously for five minutes in soap and water with a stiff brush: two minutes in a 1-2000 corrosive sublimate solution: and one minute in a 1-1000 corrosive sublimate solution.

The patient was put on a metal table, painted white, the only special peculiarity of which is that it has a sort of funnel and spout at one end to carry all the injected fluids and discharge from the vagina into a large tank attached to the legs of the table near the floor.

The administration of ether was begun. A midwife washed the external genitals of the patient for five minutes with soap and water and followed this with a 1-2000 corrosive sublimate solution. The feet, legs and lower part of the abdomen were covered with towels wet with a 1-2000 corrosive sublimate solution. The legs were held in a flexed position by the two assistants. The operator cleansed the vagina by injecting into it one liter of a 2½ per cent. carbolic acid solution and at the same time scrubbing the vaginal walls with his fingers. The injection apparatus used is quite simple: consisting of a large glass funnel, about one yard of rubber tube, and a slightly bent glass injection tube about seven inches long. This glass injection tube is sterilized by boiling, and kept in a 2½ per cent. carbolic solution. When it is needed no one touches it but the operator, who takes it from the solution and inverts it into the rubber tube which is held by a midwife.

At this time an examination through the vagina was made. The cervix was found incompletely dilated, and the right hand presenting, over which a loop of tape was slipped. The operator lubricated his left hand, both inside and out, with vaseline, which was kept under a 2½ per cent. carbolic solution: then inserting his hand through the cervix, he passed it over the breech of the child, and grasped and brought down the left leg. The fœtal heart sounds were listened for and found to be good. The vulva and outlet of the vagina were washed by running over them a 2½ per cent. carbolic acid solution. Traction was made and the baby delivered. The left arm was delivered by sweeping it over the face. The right arm had been kept down by the tape attached to it. The delivery of

the head was quite difficult, but was finally accomplished by traction with the finger in the mouth, assisted by very strong pressure from above.

The cord was immediately clamped by two pairs of catch forceps and cut.

The child was considerably asphyxiated. An assistant first cleared the mucus from the mouth with his finger, and then cleared the pharynx by sucking the remaining mucus through a flexible tube. He then used a modification of Sylvester's method of artificial respiration; placed the child in a warm bath, and from that sprinkled it with cold water, rolled it in a thin blanket, and rubbed its back vigorously with a piece of flannel; and then, after spanking it soundly, he finally induced it to breathe.

As soon as the child was delivered the vagina was again washed out with a carbolic acid solution, 2 per cent. The placenta and membranes were delivered spontaneously. A pair of Sim's specula were placed in the vagina, one above and one below, and a large laceration in the left side of the cervix was sewn up with silk. The instruments and silk used for this operation had been sterilized, and were kept during the operation under a 2½ per cent. carbolic solution. The uterus was now injected with one litre of a 5 per cent. carbolic acid solution. The patient was put to bed; an ice bag and a loose binder placed over the uterus; and cans of hot water placed near the sides of the body and limbs. As the uterus showed some tendency to relax, two hypodermic injections of a 10 per cent. solution of ergotine were ordered. Before they were given the syringe was washed out with a 2½ per cent. carbolic acid solution, and the skin over the front part of the thigh where the needle was to be inserted was washed with the same solution.

The census of student population in France, which is taken every year on January 15, gives a total in all faculties for this year of 22,328, as against 20,785, the number for last year. Of these students Paris claims 9,837, the provincial schools having 12,121. There are, however, 4,500 students of medicine and pharmacy in Paris as against 3,549 in the provinces. The figures thus given do not include the "free" or "Catholic faculties." These had in all 931 students in 1891; this number has now risen to 1,022.

A dazzling Hahnemannian luminary states in one of our dailies that camphor is a specific for cholera, the mortality at Naples in 1884, under the camphor treatment, being only 0.15 of 1 per cent. (truly wonderful!), whereas under "allopathic" treatment the mortality was over 50 per cent. No doubt the 998½ per mille recoveries were cases of homœopathic cholera. As a sure and safe—certainly safe—prophylactic measure against the Asiatic scourge it is recommended to either wear a copper plate next to the skin, it having been ascertained that copper miners and other workers in copper or brass are immune, or else to put half a teaspoonful of milk of sulphur into each stocking and go about one's business. This is both easier and cheaper than to procure pure drinking water and enforce cleanliness in other respects, and as it is said to never fail, there will be no need of further investigation of the nature of cholera, for the only practical object of such investigation is to find the means of prevention or cure.—*Pacific Med. Jour.*

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BALTIMORE, SEPTEMBER 10, 1892.

Editorial.

VACATION NOTES.

In spite of our metrical reflections on the dangers of summer resorts, and the possibility of the maintenance of health in our great cities in summer time, we were compelled to flee for our lives to the mountains of Virginia, leaving the JOURNAL for a week to the care of our friend, Dr. Rowland.

Taking the train at night over the Chesapeake and Ohio road, we arrived next morning at Gala Water station, on the James river, whence a short walk brought us to Dagger's Springs. This delightful resort of Botetourt County, nestling among the Blue Ridge mountains, is a type of the old-fashioned southern "springs." Beyond a broad lawn dotted with shady oaks lies the "hotel," a white, wooden two-storied building with gable roofs; and down one side of the lawn runs a long row of wooden one-storied, white-washed "cottages" some 20 in number, each two cottages being joined by a tall stone chimney, built against the house-walls, and serving both alike. Some years ago Dagger's enrolled upon its books the wealth and fashion of the south. Now it is content to offer a quiet resting place to the jaded city folks who long for a cool, shady place away from the "madding crowd." Its recreations are eating, sleeping, trout-fishing in the mountain brooks, and bass-fishing in the James, and, in autumn, bear and deer hunts. A few minutes' walk takes the pedestrian into the dense mountain forest. The energy of the guests furnishes simple recreations. There are iron, sulphur and lithia springs on the premises. Baths in a pool supplied by the lithia spring are much enjoyed. Arriving at Dagger's, we dropped thediet of cracked ice and milk, to which the city heat and dust had reduced us, and in two days were able to go straight through the bill of fare.

In returning to Baltimore, we visited the famous White Sulphur Springs, of Greenbrier County, situated among the mountains on the western slope of the Alleghanies, in West Virginia. We found that the fashion and throng had

already vanished, as the "season" lasts but five or six weeks, The vast pillared dining-room of the hotel, seating twelve hundred guests, bears testimony to the popularity of "the White." The grounds are flanked by more than a hundred neat cottages. Every variety of bath that invalidism can require is supplied, including *sulphur mud baths*. The baths and water have great reputation for the relief of all sorts of chronic debility, rheumatism and gout.

To the editorial mind the quiet and simplicity of such places as Dagger's seems more refreshing than the gayety and formality of more fashionable resorts.

ELECTROCUTION IN NEW YORK.

The following is taken from the editorial columns of the *Medico-Legal Journal*, published in New York. The article is written in a dispassionate spirit and probably reflects the average of medical and legal opinion on the subject. There have been so many varying and animated discussions about the expediency and propriety of using electricity to put criminals to sleep without an awakening that a calmly expressed view, like the following, is very welcome.—The repeal of the sections of the bill prohibiting the publication of the details of capital executions by electricity will doubtless terminate the objections to the use of electricity in capital punishment, from except the occasional objector, and, of course, from those who oppose capital punishment for crimes at all.

The leading New York journals published minute details of the last execution, at Sing Sing, and the New York *Herald* had an extensive illustration of the execution itself, as did several other of the daily journals.

The fact was, however, demonstrated beyond doubt or cavil that death was instantaneous and painless.

From a scientific standpoint, the method of execution now employed may be said to be completely successful.

I observe that a movement has originated in the French Senate to introduce electrocution in France.

A distinguished member of that body has brought up the question there, based upon the success of the executions in the State of New York.

I consider the guillotine as instantaneous in its action, and it must be painless, but the shedding of blood is objectionable, and must, to some minds, be revolting.

All things considered, so long as the death penalty is inflicted, death by electricity is less objectionable than by any other mode now known or practised."

REQUIREMENTS OF CANDIDATES FOR ARMY MEDICAL POSITIONS.

We have just received a circular announcing the coming examination for army medical offices (see page 1012), and giving the salaries paid, etc.

The following is the general plan of the examination:

I. The physical examination will be rigid; and each candidate will, in addition, be required to certify "that he labors under no mental or physical infirm-

ity, nor disability of any kind, which can in any way interfere with the most efficient discharge of any duty which may be required."

II. Oral and written examinations on subjects of preliminary education, general literature, and general science. The Board will satisfy itself by examination that each candidate possesses a thorough knowledge of the branches taught in the common schools, especially of English grammar, arithmetic, and the history and geography of the United States. Any candidate found deficient in any of these branches will not be examined further. The examination on general science will include chemistry and natural philosophy, and that on literature will embrace English literature, Latin, and history, ancient and modern. Candidates claiming proficiency in other branches of knowledge, such as the higher mathematics, ancient and modern languages, etc., will be examined therein, and receive due credit for their special qualifications.

III. Oral and written examinations on anatomy, physiology, surgery, practice of medicine, general pathology, obstetrics and diseases of women and children, medical jurisprudence and toxicology, materia medica, therapeutics, pharmacy, and practical sanitation.

IV. Clinical examinations, medical and surgical, at a hospital, and the performance of surgical operations on the cadaver.

Due credit will be given for hospital training, and practical experience in surgery, practice of medicine, and obstetrics.

The Board is authorized to deviate from the general plan whenever necessary, in such a manner as it may deem best to secure the interests of the service.

The Board reports the merits of the candidates in the several branches of the examination, and their relative merit in the whole, according to which the approved candidates receive appointment to existing vacancies, or to vacancies which may occur within two years thereafter. *At the present time there are twelve vacancies to be filled.*

An applicant failing in one examination may be allowed a second after one year, but not a third.

No allowance is made for the expenses of persons undergoing examination, but those who are approved and receive appointments are entitled to transportation in obeying their first order assigning them to duty.

Copies of examination papers used by the Board in session in New York City are appended to the circular as an illustration of the general character of the questions submitted to the candidates. We suppose that these may be obtained on application to C. Sutherland, Surgeon-General, Washington, D. C.

THE BOARD OF MEDICAL EXAMINERS FOR MARYLAND.

We learn from the daily papers that this recently appointed Board, of which Dr. William F. Lockwood is secretary, will hold the first regular examination on the 6th and 7th of October. All persons to whom the recent Medical Act applies are requested to make written application for license by October 1st to the president of the Board, Dr. Samuel T. Earle, Baltimore.

Reviews, Books and Pamphlets.

The Principles and Practice of Bandaging. By Gwylim G. Davis, M. D. (Universities of Pennsylvania and Goettingen), Assistant Demonstrator of Surgery, University of Pennsylvania; Surgeon to the Out-Patient Departments of the Episcopal and Children's Hospitals; Assistant Surgeon to the Orthopædic Hospital. 1891: Geo. S. Davis, Detroit, Mich. Large octavo, cloth, pp. 60; $3.

Believing that "good results in fractures and efficacy in surgical dressings depend just as much on the attention given to the bandaging as do the results in abdominal surgery to the manipulations employed in them," the author presents in a clear but concise way the important points of the art of bandaging. An important and attractive feature of the work is the presence of 170 neat illustrations, from outline drawings by the author, after nature or after photographs. We recommend it to the attention of our readers.

National Sanitarium for the Treatment of Pulmonary Diseases. Remarks of Hon. Jacob H. Gallinger, of New Hamphire, in the Senate of the United States, April 11, 1892.

Abstract of the Minutes of the Meeting of the State Board of Health of Illinois, at Chicago, July 27, 1892. Published by the Board of Health.

Lists of medical colleges in North America are given, arranged according to years of study and courses of lectures required for graduation.

Brathwaite's Retrospect; Uniform American Edition, Part CV, July, 1892. New York: G. P. Putnam's Sons, 27 & 29 W. 23rd St. W. A. Townsend Publishing Co., 153 Broadway.

Cerebral Meningitis. By Martin W. Barr, M. D. Physician's Leisure Library, Price 25cts. George S. Davis, Publisher, Detroit, Michigan, 1892.

Medical Progress.

TYPHOID FEVER.

The following extracts from an address of Sir C. A. Cameron, President of the Irish Medical Association (*Lancet*, June 11), is worthy of perusal, as, indeed, is the whole article:

Dublin is a city with an undue amount of typhoid fever in it. It is supplied with pure water drawn from a distant source. Its local wells have fallen into disuse. Its street sewers are as good as those in the English towns. Like other places, its milk supplies may be now and then infested with typhoid poison. The prevalence of typhoid fever in Dublin in 1889 and 1891-2 was by many persons attributed to the consumption of oysters, and for a time so great was this oyster scare that the sale of the mollusc nearly died out. In Belfast the same idea prevailed, but not so generally. I have repeatedly detected sewage in oysters taken from the shores of Dublin Bay. Oysters, mussels, and other lamellibranchiate molluscs are often eaten uncooked, and their shells enclose a liquid which is also often drank raw. Although oysters, when deserted by the tide, usually keep their valves closed, they do not invariably do so, and therefore at low water sewage trickling down the shore is likely to find its way into the interior of the oyster and other shell fish. I would prefer having my oysters taken from the lonely coasts of Clare and Kerry than from the estuaries of rivers which receive the filth of large towns. It is possible that vegetables taken from an infected soil

might be the vehicle of the disease. Salad radishes, and other esculents, are often brought into the house without having been separated from the soil in which they have been grown. It might happen that, if eaten without being perfectly washed, they might introduce the microbe of typhoid fever into the body. Although infected food may cause cases of typhoid fever in Dublin, it is not probable that they are more numerous there than elsewhere; we must therefore look for some other more common source of the disease than infected water, milk and other foods. Of course the house drains may be blamed for the prevalence of the disease. I examine, or cause to be examined, the sanitary condition of the houses in which it occurs; in a large proportion of them defects are detected, the traps are out of order, the drains are choked up with fat or other obstruction, or they may consist of rubble—in short, the usual sanitary defects found in so many houses when carefully overhauled are detected in nearly half of the houses examined. On the other hand, the disease constantly makes its appearance in houses where no defects can be detected, where the "smoke test" shows no leak of drain or defect of trap, where the water-closests are of the most recent construction and in good working order and where the water is taken direct from high-pressure taps.

As typhoid fever presents considerable diversity, not only in individual cases but in its epidemics, it is only reasonable to suppose a similar variety in the microbes which produce it. This may account for the somewhat conflicting accounts which bacteriologists have given in reference to the micro-organisms found associated with the disease.

The means which we must use in order to eliminate typhoid fever or lessen its ravages are numerous, and on the whole costly, and all directly or indirectly relate to the ground. A supply of pure water is absolutely necessary. The disease is propagated by means of water, but that which we use is gathered from the ground, and consequently from the latter it derives its pathogenic organisms. London is a city in which the water carriage of excreta is general, but it is fairly free from typhoid fever. Bolton, Preston, Salford, and other towns where water-closets are few, have excessive typhoid fever death-rates. I attributed the prevalence of typhoid fever in Dublin to the system of storing excreta in pits, generally having a mere clay bottom. This practice, continued for centuries, has ultimately caused the cells to become impregnated with filth and its organisms. The development and retention of those organisms are favored by the circumstances that subsoil drainage of a large part of the city is very defective, and I attribute in part to this condition of the soil the undue amount of typhoid fever to which I have so often referred. I look to its thorough drainage and its freedom from pollution as the two important means of lessening the amount of typhoid poison in it. As the microbes can only escape when the outer layer of soil is dry it is well to prevent dust rising from the roadways, by having the latter well watered in hot and dry weather. A most important preventive measure is to keep the soil from pollution by fæcal matter, or any kind of organic matter, upon which microbes could develop. We should be as careful not to pollute our ground as our air. I am convinced that typhoid fever is often caused by underground air entering our dwellings. This may be to a great extent prevented by having even the thinnest layer of asphalt or allied material covering the whole of the site upon which the house rests. No air or moisture can pass through such a layer. As microbes are most abundant in the upper layers of soil, the water from superficial wells should not be drank. The fact that typhoid fever is the one zymotic almost equally fatal in town and country may be due to

the use of water from very shallow wells by the rural population. The lower the well the more likely is its water to be free from microbes. I found in a very deep well that two kinds of water were present: near the bottom it was hard and comparatively free from bacteriological life; near the top it was soft, loaded with organic matter, and teeming with micro-organisms.

ON CERTAIN DIURETIC DRUGS.

Speaking of dropsy, Dr. Haig (*Lancet*, July 9th) says: All drugs that hinder the solubility of uric acid and clear it out of the blood relax the arterioles and cause diuresis, and indeed not a few drugs whose diuretic action is well known owe this property entirely to their action on uric acid and so indirectly on the arterioles. Thus opium, mercury, iodide of potassium and other iodides, salicylate of soda, caffeine and lithia salts, all produce more or less diuresis and diaphoresis, and all have this also in common—that they clear the blood of uric acid. Opium is often used, either alone or in combination, for its diuretic or diaphoretic properties. I have shown that it raises the acidity, diminishes the excretion of uric acid, and clears the blood of it. A good deal has been written about the diuresis produced by mercury and I have shown that it forms an insoluble compound with uric acid, clears it out of the blood and relaxes the arterioles. Iodides also are fairly well known as diuretics, and my researches show that at the time they cause diuresis they diminish the excretion of uric acid and clear it out of the blood, thus allowing the arterioles to relax. Further, the uric acid thus held back passes through the blood when the drug is left off, causing contracted arterioles, headache and scanty urine; in fact, a rebound, just such as is met with after opium, mercury, iron, lead, lithia, or any other members of this group. A good deal also has been written about the diuresis produced by salicylate of soda, but its effects in this direction are entirely dependent on the fact that it clears the blood of uric acid. Unlike the drugs I have already mentioned, it clears the blood of uric acid, not by rendering it insoluble and retaining it, but by rendering it soluble and producing its elimination by the kidney, and a knowledge of this fact gives us the explanation of an important point in which the diuresis produced by a salicylate differs from that produced by the before-mentioned drugs. Take a dose of opium, mercury or an iodide, the diuresis they produce comes quickly within a few hours of swallowing the dose—*i. e.*, they quickly clear the blood of uric acid and relax the arterioles; but with a dose of salicylate this is not so. Take fifteen grains of salicylate of soda three or four times in one day, the urine will not be at all profuse; on the contrary, it will be rather scanty. Continue the same dose next day and towards the end of the second twenty-four hours there may be a marked diuresis.

Now, the examination of this is simple. On the first day of its action the salicylate meets with a large amount of uric acid and passes a great deal of it through the blood and out by the kidney. The arterioles are consequently contracted and there is no diuresis. On the second day, however, the immediately available supplies of urate run short and excretion falls down almost to the level of formation. There is but little urate in the blood, the arterioles can relax and diuresis results. If a patient has a large amount of urate in store the diuresis with salicylates may not occur till the third day, but in my own case it comes almost invariably about the end of the first thirty-six hours. It is evident, then, that the diuresis produced by a salicylate is not due to its direct action on the arterioles, but to its direct action on the amount of urate contained in the blood, and varies in accordance with the amount of this substance that it meets with. Precisely the same thing holds with the alkalies, soda and potash, as we shall

see presently. Their first action is to increase the excretion of urates and the amount of these passing through the blood. The arterioles are therefore contracted and the urinary water is scanty. Later on, when they have eliminated most of the urate, the arterioles relax and there is a diuresis, or if the alkalies are left off this occurs at once, but as alkalies are much less powerful excretants of urate than salicylates the blood is not so quickly cleared of urate and the relaxations of arterioles and diuresis do not occur for several days. Caffeine is well known to cause diuresis. I have pointed out that it diminishes the excretion of urates and relaxes the arterioles, and is well known to be useful in conditions of migraine and depression, no doubt from its action on the urates in the blood. Salts of lithia, again, produce a marked diuresis and this diuresis comes quickly, resembling that produced by opium, mercury and the iodides and differing from that produced by salicylates. But lithia salts act as alkalies, increasing the alkalinity of the blood and diminishing the acidity of the urine, and we have just seen that the alkalies (soda and potash) increase the secretion of urates and diminish the urinary water. Here again, as in the case of salicylates, we have the most absolute proof that the scanty urine or diuresis produced by drugs is due not to their action on the vessels, but solely to their influence on the solubility and excretion of urates, which have a powerful influence on the vessels. What is the action of lithia salts on the excretion of uric acid? They greatly diminish the excretion of uric acid, clearing it out of the blood and relaxing the arterioles; hence they produce diuresis. Soda and potash increase the uric acid and diminish the water.

THE RADICAL CURE OF INGUINAL HERNIA IN CHILDREN.

Broca (*Revue Mensuelle des Maladies des l'Enfance*, April, 1892) describes the operative treatment of inguinal hernia in children, with report of seven cases.

This operation is of little importance in very young children.

1. The tissues are thin and delicate.
2. The parts are small and difficult to reach.
3. A thorough anatomical knowledge is necessary.

Through fear of operations many surgeons have adopted other measures—especially the application of a bandage. This sometimes does result in the cure of these cases, but its application must be continued from two to three years. If the hernia be complicated by ectopion of the testicle, then operation must be resorted to. Operation in very young children—from one to three years—would only be justifiable where a gradually increasing hernia should suddenly become irreducible or strangulated. Strangulation is a rare condition at these ages. Colotomy was formerly done in very young children for strangulation, with considerable success, but Broca believes the operation is rarely if ever necessary. Sometimes strangulated hernia can be reduced by pressure and carefully applied taxis.

Two reasons are given by some authors why operations in earlier years should not be performed.

1. Operations in children up to five years are generally grave.
2. Before five years the continued use of the bandage generally cures.

But if great care should be taken during the operation and in the after-treatment of the wound there is but little danger. A congenital hernia, without being a pro-peritoneal hernia, may have a dilatation, retro-peritoneal or pro-peritoneal. These conditions were found in four adults operated upon. He thinks that pressure will cause obliteration of the inguinal canal; but how can that possibly effect this pro-peritoneal pocket?

Of the seven cases reported, the ages varied from five months to twelve years.

One case at five months was cured by means of a bandage. The remaining six cases were all operated upon, and only one was complicated by ectopion of the testicle. All the cases resulted in cures in from four to eight weeks.—*University Medical Magazine.*

CEREBRAL SURGERY.

Hitzig (*Berliner klin. Wochenschrift*, 1892, No. 29, p. 713)has reported the case of a mason, twenty-nine years old, who, following a blow in the right frontal region, complained of pain at the site of the injury, with impairment of memory, defective intelligence, and attacks in which paresis of the left hand appeared, while the mouth was drawn to the left; speech and deglutition were likewise slightly affected. Subsequently, vision became impaired upon the right, and then upon the left. There had been no vomiting; and there was no alteration of the pulse The head was bent strongly forward and slightly to the left; the left shoulder drooped somewhat. There was bilateral papillitis and concentric limitation of the visual fields. The muscles of the right side of the face were paretic. The tongue was protruded a little to the right. There was also loss of power in the left upper extremity. There was weakness of lower extremities, slightly the greater upon the left side. Sensibility was not deranged. The knee-jerks were exaggerated, the left in greater degree than the right. Ankle-clonus was present upon the left, and the skin-reflexes were exaggerated. In the right temporal region, in a situation corresponding with the anterior half of the origin of the temporal muscle, was a doughy tumefaction, painful upon pressure. A diagnosis of a tumor of the bone exerting pressure upon the brain in the temporal region was made, and operative procedure decided upon. A large extent of bone was removed in the right temporo-parietal region, leaving an opening in the skull of about 3½ by 4¼ inches. The bone in places was thin: in others, thickened. A large growth was found arising from the brain and penetrating the dura. The neoplasm was carefully removed. It weighed nearly nine ounces, and proved to be a mixed sarcoma. The patient recovered absolutely from the operation, without noteworthy aggravation of his previous paretic condition. —*Medical Progress.*

SLEEPLESSNESS.

Whether, as appears likely, sleeplessness is more characteristic of our own days than those of our predecessors, or that, in accordance with a scientific fashion, it is now more noticed, we certainly hear of its prevalence with somewhat startling frequency. The nostrums proposed for the cure of this disorder are numerous. Many, if not most of them—we do not for the moment speak of narcotic drugs—are empirical, and are cast upon the public intelligence without any conscious reference to causes actually at work upon the brain and other nervous tissues. It does not necessarily follow that they are valueless, and we should no more think of repudiating their ordinarily legitimate exercise than of refusing the occasional aid of such medicinal agents as may be trusted safely to discharge the same needful function. It is to be understood, however, that we would, wherever possible, avoid, and replace by simpler non-medicinal methods, even such occasionally useful aid. This attitude is but rational, if we consider that the true object of treatment is never by choice merely palliative, but curative, and for cure there is needed the detection and removal of an active cause. The revelation of the causes of insomnia is, indeed, no simple matter. This much, however, we may say—namely, that just as the state of the brain in normal sleep implies a quiescent cerebral circulation somewhat reduced in volume, so in those

whose nights are habitually restless we shall commonly find a condition of cerebral vascular tension. This, let it be noted, is not incompatible with general anæmia or with defective brain nutrition. There is, indeed, nothing so conducive to local vascular congestion as the constant exercise of a weakened organ. Mental worry thus acts upon the jaded brain, and we need not wonder, therefore, that it "murders" sleep. The true means of relief is as clear as it is often impossible. In such cases, however, and still more in others where adequate, or even more than adequate, nutrition is maintained, we find a simple and ready antidote in physical exercise. Muscular activity, in fact, may be employed to balance nervous exhaustion. There is a transference of vascular excitement, and of tension, with corresponding relief at the site first affected. Further, the same process implies a stimulation of the general metamorphic energy and the removal from the tissues of irritant excretable products. This brings us to another cause of insomnia, particularly of that which we sometimes observe in the gouty and rheumatic. It is probably on the ground of removal of such superfluous substances that we must explain the salutary action of the traditional "night-cap" of hot water, or the boiled onion, a stimulant of the kidney, at supper. Where mental over-activity or irritation has to do with insomnia, the influence of change —that is, of a change in thought—should have a trial. It is no doubt a blind groping after this remedy that induces some to read themselves asleep. Better in several ways is the practice introduced by the German, Kant, who spent some time before he retired for the night in cutting off by an effort of thought each mental occupation of the previous working hours. We might, however, multiply the stock of remedies without meeting all possible needs. The desirable course for any sleepless unfortunate to adopt is obviously not to resort to sedative drugs to allay his distress, but to seek the advice of his trusted medical attendant and its remedy in the discovery and the removal of its cause.—Editorial in *Lancet*.

CHIMNEY SWEEP'S CANCER.

In the *British Medical Journal*, Dr. Butlin, of London, writes:

Notwithstanding its comparatively mild nature, there is not the least doubt that the disease is cancer. Its life history is that of commencement in the form of a wart or warts on the scrotum, which are so common and so constant a precursor of the cancer that the "soot wart" is as well known as the "soot cancer." The warts may exist for years, and some sweeps are covered as to the scrotum with soot warts, not one of which need become cancerous. But in the course of time, probably owing to some especial irritation, one of the warts grows slowly larger, becomes more prominent and at the same time more deeply fixed, and its centre ulcerates. At this period it is probably decidedly cancerous, although it is difficult to be sure of the moment which the actual change from the innocent papilloma to the malignant carcinoma takes place. Commencing on the surface of the scrotum, the cancer may remain during a long period scrotal, and may spread along the skin. On the other hand, it frequently penetrates more deeply until it reaches the tunica vaginalis and even the testicle, which may be laid bare and in time destroyed. The primary disease seldom, in these days of early operations for cancer, exhibits the same terrible aspect as it appears to have done before the days of chloroform, when it sometimes destroyed everything between the anus and the pubes, and resulted in a horribly foul and offensive sore, against which no treatment availed.

Secondary affection of the groin glands is frequently observed, but is often long delayed. In some cases the first enlargement of the glands is simply due to

irritation, not to the formation of cancer in them: for their subsidence has been so frequently noted after the removal of the primary disease that it has been almost an axiom of the operative surgery of the disease that enlargement of the groin glands should not contraindicate a radical operation, and that the glands should not be removed if their enlargement has been of short duration. On the other hand, their malignancy in many cases is proved by the steady progress of the glandular disease, the deep ulcers which form in them in the course of time, the character of these ulcers, and the fact that death has occurred in several, if not in many, cases from the advance of the ulcer into the femoral or iliac artery. Death may be long delayed, even in cases in which the progress of the disease has not been stemmed by operation. But in the course of time the patient's strength is slowly wasted by pain and profuse discharge from ulcers in the scrotum and groins, and he dies worn out by the disease. Of the occurrence of secondary deposits other than those in the glands little is known. Few of the patients die in the general hospitals, and in these few cases either no examination has been permitted after death or it has so happened that no secondary cancer has been found. I take it that, as is the case with similar cancers of some other parts of the body—notably the lower lip and tongue—secondary disease, with the exception of secondary affection of the glands, is not common. That it may take place, however, I cannot doubt, for I have found an observation by Mr. Travers of the examination of the body of a sweep who had died of recurrent cancer of the scrotum and what I believe to have been numerous cancerous nodules scattered on the surface of the peritoneum, for Mr. Travers concludes his account thus: "It was remarkable that the testicles, though exposed and shrunken, were not affected by ulceration; on inspection, the entire peritoneal surface was found studded with the small white tubercle of scrofula."

The continuous invasion of contiguous tissues, the steady progress of the disease from bad to worse in spite of every treatment save removal, the secondary affection of the lymphatic glands, the similarity of the ulceration of the glands to that of the primary disease, all tell plainly the cancerous nature of the disease, even if there were not the further proof afforded by the microscope. From that we learn not only that it is cancer, but that the structure is that of the great family of skin cancers, squamous-celled carcinoma or epithelioma.

It is needful to be thus precise in furnishing the proofs of the cancerous nature of the disease on account of certain peculiarities which it exhibits. Two of them are of especial interest: the affection of lymphatic glands years after the successful removal of the primary disease, and the affection of the groin glands without primary disease of the scrotum or neighboring parts.

CONGENITAL CONTRACTION OF THE COLON.

An interesting case illustrative of this condition is given by Dr. Dodd in the *Lancet*. He says:

In this case (a male infant) unusual straining at stool was the earliest symptom which attracted the attention of the nurse, but the infant notwithstanding thrived noticeably during the first three weeks. At first there were one or two actions of the bowel each day, but very shortly only every other day. About the end of the third week sickness commenced, occurring from five to ten minutes after taking the breast, and at that time only, which was then thought probably due to too frequent suckling. This symptom, however, increased in severity, the amount rejected at first being only slight; but in a few days from its commencement the mother thought the whole meal, or nearly so, was returned. I should

mention that the character of this sickness was peculiar, the vomited matter not simply rolling over the edges of the mouth, but "shooting out" (if I may use the expression) beyond the mother's lap into the room. There was evidently now a good deal of pain, the child lying curled up, with the thighs flexed tightly against the abdomen, the feet crossed, and crying at very short intervals night and day. At the fifth week there was a cessation of all symptoms for about seven days, but then sickness, constipation and pain returned. Throughout there was never any distension of the abdomen, but double inguinal hernia was produced at a later stage, as a result of the perpetual crying and straining. At the seventh week Dr. E. G. Whittle saw the case with me, and chloroform was administered, but nothing was revealed by examination. No localized enlargement, tumor, or anything unusual could be detected, and we came to the conclusion that there was some congenital deformity existing in the bowel, and thought that no operation was justifiable. Constipation increased, drugs and enemata gradually becoming useless. The motions at first were normal in appearance, but in the later stage resembled thick yellowish-brown paint. It was curious that during the last fourteen days of existence no sickness whatever occurred, and yet there was not any distension of the abdomen and only very slight action of the bowels—in fact, I thought that during that period the little that did follow the enemata was simply from the lower part of the colon. Wasting commenced after the third week, the child gradually sinking from exhaustion at the end of the twelfth week.

The necropsy, at which Dr. E. G. Whittle kindly assisted me, was made twenty hours after death. Rigor mortis had not set in. It revealed congenital contraction of the ascending and transverse colon, which was throughout but little larger than an ordinary lead pencil. The head of the cæcum was normal; the vermiform appendix was about two inches and a half in length; the descending colon, sigmoid flexure and rectum were distended, but normal, with the exception of partial contractions of an annular character of the sigmoid flexure; the small intestine was abnormally narrow: the ileum for a few inches before its junction with the cæcum was very much contracted: the stomach was peculiar in shape, resembling an hour-glass contraction near the the cardiac end. All the other organs were normal.

HÆMORRHAGE AFTER TONSILLOTOMY.

The danger which sometimes attends this simple operation and the means of combatting it are of such importance that the following communication by Dr. Rattray to the *British Medical Journal* is worthy of attention:

The patient was a strong, full-blooded youth of 20 years. He informed me that in consequence of repeated attacks of inflammation of the tonsils they became greatly enlarged, in spite of the means had recourse to for reduction. As his breathing became seriously impeded, one afternoon I was urgently requested to see him. On my arrival, I stated that now the time had come when, to save his life, a large piece of both tonsils must be removed.

The operation was skilfully performed by an eminent Edinburgh surgeon. At the end of four hours most profuse hæmorrhage took place from the cut surfaces. Luckily I was soon at his bedside, and found my patient blanched and all but unconscious; heart and pulse acting most feebly.

Treatment: (1) Iced brandy in water; (2) application of solid nitrate of silver, which made an impression; (3) external pressure; (4) direct and firm application of the liq. ferri perchlorid. fort. on two or three occasions staunched the bleeding; at the same time I gave 10 drops tr. digitalis every four hours. Perfect recovery in three weeks.

Recommendations of Therapeutic Agents.

Some Remarks on the Value of Vegetable Alteratives.—Speaking of the elements of those medicines which serve a useful purpose in exhaustive and debilitating diseases, Dr. Manley says that there are limitations to the province of physiological chemistry or bio-chemistry, in being able to satisfactorily explain the *modus operandi* of very many of our most valuable medicinal agents. This is particularly true of the vegetable tonics, when administered in wasting diseases. We may prescribe iron, arsenical, quinine or other salts in malarial, tubercular, or syphilitic anæmia, occasionally, in vain, when, if we place our patient on fresh infusions, decoctions or tinctures, immediate benefit will follow. The profession is not by any means in accord with those who would have us believe that the time has arrived when medicine can be prescribed according to any set of rules, whatever scientific basis their construction may rest on.

Warburg's tincture, one of the most valuable anti-malarial remedies known, unfortunately is a secret, quack remedy, though owned by the British government. Huxham's tincture, so long a secret compound of the Birmingham chemist, is now common property of the profession.

Cod-liver oil and its many preparations have held their own well in pulmonary tuberculosis. But there are many phases of surgical tuberculosis and those conditions of malnutrition resulting from syphilis, in which the oil is not well borne. Here the vegetable tonics, particularly those rich in the alkaline salts, are invaluable. The tincture of hops, decoction of sarsaparilla, gentian, columbo, or chamomile, either may be taken alone or in combination. A valuable combination of herb extracts was elaborated in the Southern States by members of the medical profession, as a substitute for mercury and the potassium iodide, during the late war of the Rebellion, when all pharmaceutic supplies were shut out by the blockade and the advancing lines of the enemy. It is known to pharmacists and practitioners as Verrhus Clemiana, and is composed of clematis-erecta, prinus-verticillatus, fraxinus Americana, rhus-glabrum, and one-eighth of one per cent. of venanatic acid; all indigenous in the Southern States. I have extensively employed this compound in many cases of chronic, tubercular, glandular and bone diseases, besides other wasting maladies, with excellent results. Indeed, in these times pharmacy yields a large number of vegetable elixirs, so palatable and easy of assimilation that one should always give them a protracted trial in the vast majority of tubercular or syphilitic bone or joint disease, before any sort of sanguinous operation should be thought of.—H. Manley, M. D., New York, in *Doctor's Weekly*.

Medical Items.

According to the *Revue Médico-Pharmaceutique*, of Constantinople, the Turkish Government has decided to make vaccination compulsory throughout the Ottoman Empire.

On the last day of the German Surgical Congress, Professor Wolff (Berlin) exhibited a patient with an artificial larynx. The patient speaks without difficulty and in a natural voice; he recited a piece of poetry and even sang a song, the voice sounding rather hoarse, but not in any way unnatural.

Sir Samuel Baker, in his "Albert Nyanza," after describing the symptoms of the fever which prevailed and proved frequently fatal in Africa, and was of an intermittent type, observes that "any severe passion of the mind, such as grief or anger,

is almost certain to be succeeded by fever in this country, just as full occupation of the mind was found to act as a prophylactic against it."—*Ex.*

On June 13th, Professor von Helmholtz was, by 28 votes out of 50, elected a Foreign Associate of the French Académie des Sciences, in the room of the late Emperor of Brazil. Among the other men of light and leading in the scientific world put in nomination for this honor, were Sir Joseph Lister, Professor Van Beneden, of Louvain, and Mr. Nordenskjöld, of Stockholm.

An International Congress of Dentists will be held at Chicago in August, 1893, during the World's Fair, at which, in addition to the discussion of subjects of technical interests, special committees will deal with such questions as the provision of dental relief for the poor and the appointment of dentists for the army and navy.

By order of the Council, the Annual Meeting of the Southern Surgical and Gynecological Association has been postponed from the 8th, 9th and 10th, until the 15th, 16th and 17th of November. It was thought wise to change the time of the meeting from the fact that the 8th of November is the date of the Presidential election. Everything points to a very successful session.

The Superintendent of the public schools of New York has prepared a scheme of instruction in physical exercise as a guide for the principals of the various schools in teaching gymnastics to their pupils. Although there is more or less drilling in most of the schools, there are appliances for gymnastics in only five of them. Next year, however, it is expected that this number will be quadrupled. The very wise step has further been taken of appointing a medical man to superintend the physical instruction in the schools, under the control of the Board of Education.

Dr. Piggott communicates to the *Lancet* of June 11th this pecular experience: The case occurred in an aged woman. A foreign body was found in the vagina, which eventually proved to be a wire pessary covered with india-rubber. At first all attempts at removal failed. I then discovered that it had at some period of its retention ulcerated its way through the mucous membrane of the vaginal wall, which had healed over the pessary, thus effectually fixing it by a membranous band. Removal was effected by tearing through the band with the thumb nail. Owing to the vascularity of the parts, and probability of hæmorrhage, I deemed the knife less suitable for the operation.

An Army Medical Board will be in session in New York, during October, 1892, for the examination of candidates for appointment to the Medical Corps of the United States Army, to fill existing vacancies. Persons desiring to present themselves for examination by the Board will make application to the Secretary of War, before October 1, 1892, for the necessary invitation, stating the name and place of birth, the place and State of permanent residence, the fact of American citizenship, the name of the medical college from whence they were graduated, and a record of service in hospital, if any, from the authorities thereof. The application should be accompanied by certificates based on personal knowledge, from at least two physicians of repute, as to professional standing, character and moral habits. The candidate must be between 21 and 28 years of age, and a graduate from a regular medical college, as evidence of which his diploma must be submitted to the Board. Further information regarding the examination may be obtained by addressing C. Sutherland, Surgeon-General U. S. Army, Washington, D. C.

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CONTENTS

ORIGINAL ARTICLES.

Report of a Case of Septic Peritonitis Following a Criminal Abortion. By Stephen Crowe, M. D., of Baltimore. 1013

Notes from Leopold's Clinic. No. III.—Cæsarean Section. By William S. Gardner, M. D., of Baltimore. 1015

SOCIETY REPORTS.

Clinical Society of Maryland. Stated Meeting held June 3, 1892. Ectropion of Both Upper Lids from Disease of Orbital Roof. Rupture of the Plantaris Tendon. Puerperal Insanity. 1018

EDITORIAL.

Unprepared. 1022

The "Orificial" Fad. 1023

MEDICAL PROGRESS.

Tuberculous Mastitis.—Newspaper Copyright.—Hæmorrhage into Bursæ.—Inflammation.—Death from Heart-Clot in the Early Period of Pneumonia.—The Difficulty in Diagnosis of Variola.—Treatment of Transverse Presentation by Inversion of the Body.—Secondary Hæmorrhage from Enucleation of Eye, followed by Restoration of Sense of Smell and Taste.—Methyl-Blue. . . . 1024

MEDICAL ITEMS. 1033

Original Articles.

REPORT OF A CASE OF SEPTIC PERITONITIS FOLLOWING A CRIMINAL ABORTION.

BY STEPHEN CROWE, M. D., OF BALTIMORE.

Theresa S., white, female, aged 18 years, and unmarried, was admitted to the Maryland General Hospital, at 8.30 P. M., November 3, 1891, with the following history: Being three months advanced in pregnancy, and of respectable parentage, she became anxious to avoid the disgrace which would attach itself to her maternity under the circumstances. In her hour of need, according to her own statement, she consulted a "lady friend," who inserted a tent and told her not to worry, as all would be well. When the time came to withdraw the tent, the "lady" undertook to do it, and, in the effort, broke it off, allowing about ⅔ of it to remain in the uterus, where it staid for over thirty-six hours. All this time the poor woman was in agony, and finally sent for a physician, who removed the tent and a greater part of the products of conception, after which he ordered her immediate removal to a hospital. Professor Brinton saw her shortly after her arrival, at which time her temperature was 103°, and pulse 140. Her abdomen was fearfully distended and painful to the touch. Stomach very irritable. She had vomited everything swallowed for two days. The following treatment was ordered and carried out to the letter: Vaginal douches of carbolic acid, ʒ i, to

hot water one pint, every four hours. These were continued for ten days. Spirits of turpentine, gtt. x, on white sugar, every two hours *per orem*, and turpentine stupes applied to the abdomen every two hours. The next morning her temperature was 102°, pulse 130. The vomiting persisting, the turpentine drops were discontinued, and the following ordered: bismuth subnit., gr. xii., morphia sulph., gr. $\frac{1}{6}$ and liq. calcis ʒi, to be given every hour. For ten hours the vomiting was under control and the patient was given small quantities of milk, soup, wine and ice.

At 1 P. M. November 6th, one-twelfth grain of calomel was given, and ordered to be repeated at intervals of thirty minutes till bowels moved freely. 2½ grains were taken before she had a movement. After several free actions of the bowels, the abdominal distention was relieved, and on the tenth day she was feeling good, and ate heartily. From this time on, her temperature, which had been 103°, never went beyond 99°. In addition to the above-mentioned treatment she was given quinine in doses of 3 grains, t. i. d., for about two weeks; also hypodermic injections of morphia as often as necessary. The first day she took two grains. The same quantity was given each day for the next three days. Then the amount was gradually lessened, till on the tenth day she got ½ grain, and on the twentieth day hypodermics of water had the desired effect whenever she complained of pain. On the twelfth day she was allowed to sit up for ½ hour, and each day the time was increased, till she was able to stay up all day. Her appetite began to improve as soon as she was able to sit up, and four weeks from the date of her admission she was "as well as she ever was." On December 7th, she began to complain of severe pain in the buttocks. An examination revealed a large gluteal abscess, which was opened by Prof. Brinton, and two pints of green-looking, foul-smelling pus removed. This wound healed rapidly and ten days later the girl left the hospital, perfectly well. I saw her in July last, at which time she told me that she had never felt badly nor had any unpleasant symptoms since her return home. It would be hard to say which one of the drugs played the most important part in effecting the cure. It is my opinion that the morphia, turpentine stupes and vaginal douches are each entitled to an equal amount of the credit.

1526 N. Caroline Street.

The following would indicate that telephone companies are much the same in England as in Maryland. We are happy to learn that our brethren succeeded in their revolt against excessive rates. "The telephone has now become of so much concern to the medical man both for his own use and the convenience of his patients, that the little storm that has been taking place at Sheffield in telephone matters is of some interest. It may be said that practitioners have largely made use of the telephone, but just recently the local company, which had met the needs of the profession and the public at a reasonable cost, has become by purchase merged in the National Company. Almost immediately notice was given of a new tariff, which would certainly have greatly augmented the sum paid annually by the profession and in a greater degree by many of the commercial public. The 'screw pinched' all round, and combined effort and the very likely possibility of a new company coming to the town have had the desired effect of a withdrawal of the objectionable tariff alluded to."—*Brit. Med. Jour.*

NOTES FROM LEOPOLD'S CLINIC.
NO. III.—CÆSAREAN SECTION.

BY WILLIAM S. GARDNER, M. D.,
Attending Obstetrician Maternite Hospital, Baltimore.

M. B., aged 46 years, was admitted to the hospital thirteen days before the operation. There was a history of rickets.

History of former labors:

I. February 1, 1891. Perforation.

II. May 25, 1882. Cæsarean section done in Leipzig by Professor Leopold. The child is still living and healthy. The mother went home at the end of three weeks.

III. *Present Pregnancy.*

Last menstruation between the middle and the end of September, 1891; date of conception not known; first movements of the child were felt early in February.

General condition of the body.—Height, 125 cm.; temperature, 36.5 C., pulse, 86. Muscles tolerably strong. Heart and lungs sound. No albumen in the urine; no signs of syphilis; a large abdominal hernia.

Pelvis.—Distance between the anterior superior spines of ileum, 25 cm.; between the crests of ileum, 23 cm.; through greater trochanters, 27.5 cm.: external conjugate, 16 cm.; diagonal conjugate, 7¾–8 cm.; conjugata vera, 6 cm.; the linea innominata easily felt.

High grade generally contracted rachitis pelvis, somewhat heart-shaped.

The lower part of the sacrum bent forward moderately; the promontory very deep and sharply projecting.

The spinal column straight.

Abdomen.—Circumference of abdomen, 92 cm.; symphysis to umbilicus, 19cm.; from umbilicus to the appendix ensiformis, 18 cm.; abdominal wall lax; in the lower third of the cicatrix of the former Cæsarean section is an abdominal hernia 6 cm. by 12 cm.; limbs straight; no œdema of feet or ankles.

Fœtus.—The back extends from the left side above toward the right side and below; the limbs to the right side; the breech on the right ileum; the head to the left and above. Position—first oblique.

Heart-sounds to the left below the umbilicus, 140. The quantity of amniotic water somewhat more than the average. The movements of the child frequent and strong.

Birth.—Bag of waters ruptured at 1.30 A. M. Regular pains began at 6 A. M. Completion of second stage, 3.57 P. M. End of third stage, 4.02 P. M. Duration, first and second stage, 14 hours and 27 minutes. Duration of third stage, five minutes. Pains strong.

9 A. M.—After a vaginal injection of one litre of a 1-4000 corrosive sublimate solution a vaginal examination was made. The vaginal portion of the cervix was found forwards; the os dilated enough to admit one finger; the waters already escaped; the head was movable above the anterior strait; diagonal conju-

gate, 8 cm. The cervix and vagina were again washed out and the vagina tamponed with iodoform gauze, after which the patient was given a full warm bath.

2.50 P. M.—Since two o'clock strong pains have been recurring every five minutes. The heart sounds are clear.

3.10 P. M.—The special preparation of the patient for the operation was begun. The abdominal wall was washed for five minutes with soap and water: the pubic hair shaved off: this was followed by ether and 1-2000 corrosive sublimate solution.

3.30 P. M.—The ether narcosis begun. The patient did not take ether well and for several minutes was very much cyanosed.

3.54 P. M.—The operation was begun by making a very long abdominal incision.

3.55⅓ P. M.—The uterus was raised entirely out of the abdominal cavity and the upper portions of the abdominal wound temporarily closed with four large Mujeux.

3.56⅓ P. M.—A rubber tube was placed loosely around the cervix and clamped.

3.57 P.M.—The uterine incision was made from the fundus toward the cervix and three finger-breadths to the left of the old incision. The incision struck and followed the right border of the placenta, which was situated to the left and in front. The operator introduced his hand quickly past the placenta and grasped the child by the leg and rapidly extracted it. Immediately after the extraction of the child the rubber tube around the cervix was drawn tight and clamped. The cord was clamped in two places by catch-forceps and cut at once. The child was slightly asphyxiated, but was soon crying loudly.

3.59 P.M.—The upper angle of the abdominal wound was brought together with six strong silk stitches.

4.02 P. M.—After partially separating the placenta and membranes the uterus was completely everted, all the membranes removed and the uterus was carefully washed out with sponges.

4.03 P. M.—Seven silver stitches, which had been placed in the uterus at the previous Cæsarean section, were removed.

4.06 P. M.—Nine deep silk stitches, beginning at the upper angle, were placed in the uterine wound. Twenty-one superficial silk stitches brought the peritoneum and the edges of the wound neatly together. The patient was given a hypodermic injection of ergotin.

4.17 P. M.—The rubber tube around the cervix was loosened, and the uterine contractions stimulated by gently kneading it with hot sponges. A second injection of ergotine was given. Then followed the external cleansing of the uterus with sponges, and as it was still not well contracted the kneading with hot sponges was again repeated.

4.21 P. M.—The uterus was returned to the abdominal cavity. The corpus luteum was found on the left side.

4.22 P. M.—Before placing the remaining deep abdominal stitches the hernial sac was entirely excised. Ten deep stitches were placed in the abdominal wall, but not tied.

4.28 P. M.—During the last five minutes the patient was very much cyanosed, and the pulse very rapid and weak; the uterus became large and relaxed and blood escaped from the vagina. The iodoform gauze placed in the vagina at the beginning of the operation was removed; the uterus was strongly kneaded and the coagula pressed out. On account of the hæmorrhage and the condition of the pulse, 150 cc. of a normal salt solution were infused into the areolar tissue of the left side, just below the clavicle.

4.31 P. M.—The uterus again firmly contracted and the hæmorrhage checked. The deep stitches tied and 36 superficial ones put in.

4.48 P. M.—By pressure upon the uterus no more blood can be forced from the vagina.

4.50 P. M.—The vagina was washed out and tamponed with iodoform gauze.

4.51 P. M.—The patient was replaced in bed. The pulse good and the arteries firmly contracted.

Child.—Sex, male; length, 51 cm.; weight, 3590 grm. Shoulders, diameter, 10 cm.; circumference, 35.5 cm. Breast, diameter, 10 cm.; circumference, 32.5 cm.; breadth of hips, 10 cm.

Head.—Antero-posterior diameter, 12 cm.; perpendicular diameters, 9.5 cm. and 10 cm.; transverse diameters, the greater, 11 cm.; the smaller, 9 cm.; oblique diameter, 13 cm.; the greater circumference, 38 cm.; the smaller, 33 cm.; the occipito-frontal, 35.5 cm.

Placenta.—Position in uterus was to the left side and toward the front. Its location was made out before the operation. Weight, 780 cm.; mensuration, 20 cm. by 22 cm.; form almost round.

Cord.—Length, 45 cm.; thickness, ½ cm.

Membranes.—Complete and normal.

The operating room.—The room where the operation was done is the one used exclusively for abdominal work; it is about 5 m. long by 4 m. wide and 5 m. high. The walls are lined with marble slabs, so large that two lengths placed above a narrow base reach entirely to the ceiling. The ceiling is plastered and painted. The floor is mosaic. The light is admitted by two large windows, one on the east and one on the north side of the room. Along the west wall is a row of five marble wash-basins; above them is the closet for instruments, and below them is the ventilator with a forced draught outward. The operating table is placed about the middle of the room, with the head of the patient toward the east window. The operator stands between the table and the north window. The broad marble sill of the north window is utilized as an instrument table.

Instruments.—The instruments used were sterilized by boiling in a solution of sodium bicarbonate, and during the operation were kept under a 2½ per cent. carbolic acid solution. The silk was sterilized by boiling, and was also kept

when in use in 2½ per cent. carbolic solution, and, when not in use, in a 1-1000 corrosive sublimate solution. During the operation the sponges were washed in 5-10000 corrosive sublimate solution.

The lying-in period was so nearly normal that a detailed record of it would be monotonous. For six evenings immediately following the operation 0.015 grm. of morphia was given. For five days the urine was drawn with a catheter. The pulse and temperature were taken every three hours for twelve days. The highest temperature, at the end of the third day, was 38.5 C. The pulse rose as high as 100 only twice; first, immediatly after the operation, and second, during the forenoon of the third day. At all other times the pulse varied only a few beats from what it was before the operation. The patient nursed her child from the time the milk first came in. On the twenty-fifth day after the operation I saw her sitting at the table eating soup and suckling her baby.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD JUNE 3, 1892.

The 268th regular meeting of the Society was called to order by the President, Dr. Robert W. Johnson.

Dr. Hiram Woods related a case of ECTROPION OF BOTH UPPER LIDS FROM DISEASE OF THE ORBITAL ROOF, and exhibited the patient.

When the patient, a colored boy, first came under Dr. Woods' care he had had abscesses over the upper eye-lid of each eye, which had ruptured spontaneously, leaving fistulous openings about the middle of each lid, from which pus exuded. With a probe, small areas of denuded bone could be felt about an inch back in each orbit. The patient was put upon tonic treatment, and the sinuses healed. The lids were enormously hypertrophied and the entire edge of each lid was fastened with cicatricial tissue to the edge of the orbit. Dr. Woods operated upon one eye in October, 1891, and upon the other three weeks ago. The edge of each lid was dissected from its position and stitched for the time being to the lower lid. The skin was freely undermined and the horizontal incision was converted into a vertical one. The results were highly satisfactory.

Dr. W. B. Platt read a paper on RUPTURE OF THE PLANTARIS TENDON; relating four cases that had occurred in his practice.

Dr. Chambers was inclined to doubt the existence of such a thing as rupture of the plantaris tendon. From the attachment and relations it would not be likely to rupture. The pain is usually at a distance from the weakest portion of the tendon and the ecchymosis is more abundant than we would expect to find in a rupture of a tendon. Some good surgeons incline to the idea that these symptoms point to the rupture of a blood vessel. The deep veins may be in a varicose condition.

Dr. George H. Rohé related four cases of PUERPERAL INSANITY, in which he had removed the uterine appendages, and exhibited to the Society the specimens removed.

Case I.—White woman. 33 years of age. Married at seventeen years of age. This marriage resulted in the birth of one child. In two and a half years she be-

came widowed, and four and a half years later married a second time. In 1882, she gave birth to a second child and immediately afterward suffered from puerperal mania, which lasted five months She remained well three years and then again developed insanity and was admitted to the insane asylum with acute mania. When admitted to the hospital she was excited and disposed to fight. She had especial aversion to her husband. She indulged in obscene language. She showed no improvement, but a gradual failure of mental faculties. Suffered from incontinence of urine, and paid no attention to the calls of the rectum. Exhibited great excitement during menstrual period.

Physical examination after coming under Dr. Rohé's care in 1891: Unilateral laceration of cervix up to the vaginal junction and intrapelvic induration on the same side. Perineum ruptured into the rectum.

Abdominal section performed October 6th, 1891, and appendages removed. Clinical conditions present: Right ovary cystic; left ovary cystic and adherent in Douglas' cul-de-sac; thickening and congestion of broad ligament on right side.

After-history: Patient recovered fairly well from operation. Had an attack of peritonitis, which yielded promptly to the usual treatment of purgation. The stitches were removed on the seventh day and the wound found perfectly united. December 10th, patient dresses and undresses herself. Seems much interested in looking at books. Appetite good; sleeps well; does not indulge in profane and obscene language as much as formerly. A week later, very much interested in plants and flowers in the wards, and waters them regularly. Appetite good, sleeps well; general behavior very much improved. Present time: Improvement continues. Has written several letters to her husband and to her children, showing decided interest in her family life.

Case II.—White woman, aged 37 years; married 13 years; mother of six children. Admitted to the asylum, May 16, 1890. Insanity developed during the period of lactation. Previous to insanity she was amiable, cheerful and industrious. Her mother had been insane and her father was very intemperate. Had been insane three days when admitted. Had a previous attack ten years before, probably in connection with the birth of a former child, but no exact history. Was subject to hallucinations. Thought nearly every man she met was her brother in disguise. Imagined that she had the power of healing by laying on of her hands. Had a decided tendency to expose her person. Menstrual period irregular. Emaciated, with haggard appearance. Appetite poor; slept poorly; nervous and restless during the day. Put upon a special diet of eggs, milk, beef-tea, brandy, etc., but improvement was very slow. The approach of her menstrual periods could be predicted by the alteration in her behavior in the ward.

Physical examination: Bilateral laceration of the cervix; thickening of posterior lip; intra-pelvic inflammatory induration of the left side, sensitive to slight pressure.

Operation November 25, 1891. Left ovary was found adherent. Breaking up of the adhesions occasioned some bleeding. Tube on the left side congested and convoluted.

After-history: Recovered well from the operation. Sutures were removed on the seventh day. Note, December 17th: Patient cheerful; appetite good; sitting up in her room, sewing; conversation coherent and has at present no hallucinations, no delusions; simply nervous symptoms such as are present in the majority of cases of induced menopause. At the present time is increasing in flesh and strength; complains less and less of headache and backache and converses entirely rationally. Is much interested in the work about the place and is ready

to go home at any time her husband is prepared to make the proper provision for her.

Case III.—White woman, age 39 years. Married fifteen years. Has had seven children, the last one born four months previous to her admission to the hospital in August, 1887. Before insanity, was amiable and industrious and neat about the household affairs. No insanity was ever in her family. Insanity came on suddenly after the birth of the last child. First symtom was that some one was after her trying to kill her. She used vulgar and obscene language. Tried to kill her mother. Her language in the hospital was of the most obscene character. She would tear her clothes, break the furniture and tear the plastering from the walls. These attacks were intermittent. About six months ago she began to fall off and at the time of the operation was pale and thin.

Physical examination: Deep laceration of cervix on both sides, with eversion of the lips of the cervix and enlargement of the uterus.

Operation December 15, 1891; Uterine appendages removed; small cyst in left broad ligament; one ovary was adherent; uterus somewhat enlarged.

After-history: Recovery from operation very good. From being one of the worst patients in behavior, language and general character, she became one that could be kept upon the best ward of the house. She is not well and probably never will be. She has gained in flesh; sews, goes out on the lawn, attends the dances regularly and behaves very well. This patient and the first one will probably never be well, as both are in a condition of somewhat advanced dementia; but they have become better patients.

Case IV.—White woman, aged 28 years. Native of North Carolina and resident of Baltimore City. Admitted in 1891, suffering from mania. Mother of three children. Had an attack of insanity after the birth of the first child and another after the birth of the second child. The third attack came on 12½ months after the birth of her third and last child. The second and third attacks considerably after the births of the respective children. The first attack was a true case of puerperal insanity and probably determined the others. When admitted, was in a state of excitement and indulging in obscene language. Her temperature ran up and her heart grew weak. She was put upon digitalis, eggs and milk every two hours. She gained in strength but her mental symptoms were unimproved.

Physical examination: Deeply lacerated perineum, lacerated cervix and prolapsed ovary.

Operation March 9th. Appendages removed. Great enlargement of ovaries of both sides.

In this case, hereditary taint was denied. Her menstrual periods were regular. While at home she was jealous of her husband's sisters. Was fond of drink but had not access to much of it. Was indolent and careless. Was fond of talking about sexual matters.

After-history: Three weeks after operation, mental condition good, language to physicians chaste, appetite good. May 8th, 1892, was discharged from the hospital, recovered.

This woman up to the time of the operation used the most profane and obscene language Dr. Rohé had ever heard. When she recovered from the effects of the anæsthetic she burst into tears and asked the doctor's pardon for the ugly language she had used. She never afterward used any obscene or insane language to any one connected with the hospital.

In conclusion, Dr. Rohé said: I believe that in these four cases we have a con-

tribution to the etiology of puerperal insanity. I believe that puerperal insanity is a phase of insanity that is due to absorption of septic matter, and when it is recurrent that it is the result of some reflex irritation due to an inflammatory condition in the pelvis or pelvic organs. All the cases which I have examined show some lesion of the genital canal remaining from parturition. The result of the treatment in these cases show this—that if cases are taken before structural alterations have taken place in the brain, before dementia has come on, that in the large majority of cases restitution of the mental faculties can be acomplished. There is another advantage, I believe, in this radical mode of treatment of this condition; that is, that a woman whose appendages have been removed will never have another attack of puerperal insanity at all events.

Dr. Winslow: Are these selected cases? Are they all the operations which Dr. Rohé has performed for insane conditions since he has been at Spring Grove?

Dr. Rohé: This is a series of cases due to one single cause. I have operated upon fifteen cases. In nearly every case there was some lesion of the pelvic organs. I expect to report all of these cases in the future. I believe that I will be able to report four or five as restored mentally. Nearly all have shown evidences of improvement. They are better patients; they are not so disposed to soil, they can be kept on better wards with quieter patients. This is a decided gain for the management of the hospital.

MEDICAL EDUCATION OF WOMEN IN GLASGOW.

The experiment made by the directors of the Royal Infirmary in opening certain of their wards for the clinical teaching of women has turned out a failure, and the governing authorities of the infirmary and also those of St. Mungo's College have now determined to exclude females both from the wards and from the college classes. It is about two years since the students of Queen Margaret College were granted facilities for obtaining clinical and pathological instruction in the infirmary, and at the same time the ladies attending medical classes in St. Mungo's College and other lady "medicals" were afforded the same opportunities, the Queen Margaret students, however, having their instruction separately, while the others attend mixed classes both in college and in the wards. The arrangement, however, has come to grief over the dispensary question, it having been found inconvenient, if not impossible, to carry on the very essential dispensary work of the curriculum either in mixed classes or separately, the objection to mixed dispensary classes having come, not from the women, but from the male students. To get over this deadlock the managers have decided to exclude ladies at once from St. Mungo's College and from the wards, the only exception made being in favor of Queen Margaret students, who will be permitted to attend pathological and clinical classes till the end of the summer session of 1893. All this comes as something of a shock to the friends of medical education for women in Glasgow, as unless some new arrangement is speedily made such teaching must come to an end in this city. Queen Margaret College in particular will be in a difficulty and will specially feel the hardship; it has been prospering to the satisfaction of its friends, and has only recently been affiliated to Glasgow University, which has taken over its buildings and endowments and with them all duties and responsibilities. Amongst other things it must provide clinical facilities for its lady medical students, and at first sight it is not easy to say where these are to be found. —*Lancet.*

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BALTIMORE, SEPTEMBER 17, 1892.

Editorial.

UNPREPARED.

It is more easy to find fault than to act wisely. "Hind-sight" is a more common virtue than foresight. Yet we may be permitted to put into words a few thoughts suggested by the tragic scenes now passing before the gaze of the world in New York bay.

Could not a little forethought have prevented the harrowing spectacle of the cooping up of five hundred non-infected cabin passengers for weeks in a cholera-infected ship where members of the ships' crew are daily sickening and dying of the disease? A quarantine system carefully planned before the emergency arose would surely have provided a separate refuge for this non-infected class, so that after a few days' observation they might have been dismissed to their homes.

Could not facilities have been provided for the abundant supply of disinfectants to the doomed vessel? Could not fresh water have been furnished in exchange for the supply brought from Germany? Could not experienced American physicians have been placed on board to give confidence to the terrified passengers? Could not properly enclosed boats be secured for the safe transfer of the cholera-stricken from the ships to the island hospitals? Petitions from the passengers to the Governor of the State for relief, threats of breaking quarantine in search for fresh water, and the supply of ships by private persons for isolation seem out of place in a properly planned quarantine.

We believe in the self-government of the State; but surely there is need of some national institution, not run by ward politics, which shall have authority in such emergencies to take charge of all incoming ships at whatever port they may arrive; which shall be so well directed and organized that it shall, before the invading disease has actually arrived, have made arrangements for the control of necessary separation and isolation places, whether on ship or on land, for both the

sick and the well, and for the supply of necessities to the great numbers of passengers quarantined; which shall place in control of the quarantine measures a medical staff, not at variance with the national government, and not alienated from the sympathy of the leading physicians of the seaport where the quarantine is enforced.

The experiences of New York harbor furnish a great incentive to the establishment of a national health service, free from control by party politicians, and manned by experienced physicians, appointed after severe examinations such as are now required for army and navy service. It is to be hoped that this needed measure will not be delayed until still more bitter experience has forced the matter upon the attention of the public.

THE "ORIFICIAL" FAD.

Gentle reader, the fertile womb of medical speculation has brought forth another "-pathy." Already, when but a few months old, it waxes confident and clamors lustily for notice. As guardians of the weal of medicine, and as watchmen on the heights of progress, it is incumbent upon us to inform the profession of this new arrival upon the scene of therapeutic action, and of its claims upon the attention of the public.

Like "Homœopathy," the new-born "Orificial Method" professes to have discovered a principle upon which many, if not all, human ailments may be relieved; unlike its great predecessor, its doctrines are clear and simple, free from all abstruseness of philosophical ratiocination. It reasons thus:

The vital functions of the human body are regulated by the *great sympathetic nerve-system*. The fibrils of this system are exposed to compression at the *orifices* of the body, where the sphincters are liable at any time to close upon them. Spasm of any sphincter will irritate the sympathetic nerve-endings which are included in its grasp—this irritation will throw important parts of the internal sympathetics out of gear, and cause untold disturbance of the health. Spasm of the sphincters is therefore incompatible with health, and must be removed before health can be restored. With the removal of existing sphincter spasms, the most complicated and alarming disease-states will vanish, like snow kissed by the rays of the morning sun. The proper way to relieve such spasm and to cure such cases is to stretch the contracted sphincter.

Could any reasoning be more logical? Could any conclusions be more simple?

The discoverer unfolds his discovery. Ardent disciples are fired by the mighty truth. A great search for contracted sphincters is instituted.

A patient is afflicted with chronic constipation, melancholia, and the thousand ills that follow in its train. His anal sphincter is found to be *contracted!* By the great "American operation" *the sphincter is dilated.* Astonishing recovery follows. The victim of living death awakes to usefulnees.

Another patient has for years puzzled and baffled the greatest minds of the profession. Diagnoses manifold are made; drugs by the pound are swallowed; the

patient steadily loses strength. An enquirer, of "orificial" sympathies, appears upon the scene. Eureka! The "*bladder-sphincter*" is in a state of *spasm*. It is dilated by an appropriate operation. The nerve-fibrils are released; the offended sympathetic settles down to its work again.

But what about gynæcology? It is a cold day when the "uterine surgeon" gets left! A woman has been racked with pain for years. Cancer and spine disease, consumption and liver complaint have expended all their therapeutic ammunition upon her; and yet she suffers. She consults an "orificial" enthusiast. He informs her that "*the neck of her womb is in a state of spasm!*" and that "an operation is necessary." Hope revives in her breast; her "womb is stretched;" she goes rejoicing on her way through life, telling the story of her recovery to every female she meets.

And still the scene of action widens. A man is found narcotised by opium. His respiration has ceased. He is at the point of death. A disciple of "orificialism" is called. He finds the sphincter ani *tightly contracted!* He introduces a bivalve speculum. He presses the handles; *the man breathes!* He relaxes his pressure, the man breathes no more. He stretches the sphincter again; *another deep inspiration!* Hour after hour the doctor stands guard with his hand on the speculum handle, and by intermittent pressure evokes the life-giving respirations. At length reviving conciousness rewards his faithful labors.

Adherents spring up on every side. An association is formed. An imposing journal is published.

The "ORIFICIAL SURGEON" now stands confidently forth before the public; his hand is upon the sphincter-dilator. A moment's pressure upon this magic lever, the vaive is open, the brakes are off, and the mighty wheels of the clogged sympathetic system move swiftly on in life-giving harmony.

Be this as it may, the orificial "-pathy" bids fair to move for a while down the "ringing grooves of change" to the music of shekels. Doubtless some therapeutic facts of interest will be revealed through its influence. And who can tell at what moment a hitherto unsuspected sphincter may leap into the arena, ready for countless dilatations?

Medical Progress.

TUBERCULOUS MASTITIS.

A lengthy and finely illustrated article upon this important subject is given by Dr. Henry B. Robinson, of the Royal College of Surgeons, in a recent number of the *British Medical Journal*. From it we extract a few paragraphs:

Most observers seem to agree that the lesions are found under different forms, the confluent and the disseminated.

The confluent is the most frequent of the two. It presents the form of a single, ill-defined, bossy tumor, moving with the breast on the chest wall. Its edges have not the marked boundary, as occurs in most cases of simple chronic mastitis, and it very often sends off processes into the surrounding tissues as a carcinoma does. The skin may or may not be adherent; if the latter, the tissues

beneath have become infiltrated, and thus the skin is implicated. The nipple will be retracted where the inflammatory swelling is central.

The disseminated form is rarer. In this variety we get scattered nodules, between which the tissues may or may not be sound. These nodules tend to run together and become the confluent form.

Ohnacher considered that the disseminated form was secondary to the confluent form, and due to new foci springing up around the primary centre. G. Mindry recognizes two forms of primary tubercle: (1) Very chronic—a low inflammation with induration, caseation, softening, etc.; abscesses with retraction of nipple and enlarged axillary glands. This agrees with the confluent form of most observers. (2) The intramammary cold abscess, generally associated with tubercle elsewhere. It is a tense elastic swelling, full of thin, curdy pus.

Miliary tubercle of the breast up to the present has not been recorded. The commonest clinical form, then, of breast tubercle is the single confluent tumor. The rate of increase of such growth is very variable, in some very chronic, in a few cases running somewhat an acute course. Before very long we find—and it is the commonest sequel—that destructive changes ensue in its centre, giving rise to a softened patch and the development of curdy pus. Ultimately the skin gives way, and this caseous pus is discharged from a fistulous opening. The sinus or sinuses thus formed will be found to lead down into a cavity, or intercommunicating cavities, which present ragged walls. No case has yet been recorded where calcification has taken place in lieu of the above destruction.

A general fibroid change probably results in a few cases, of which the following is possibly an example; but we could not here be certain that the tuberculous lesion had not been implanted on the top of a chronic interstitial mastitis. In favor of the tubercle being the primary disease is the fact that this one breast alone was affected, whereas in the chronic interstitial disease the majority of cases are bilateral. All the cases I have seen belong to the confluent form. According to Delbet, the outer segment of the breast is more often affected (in 10 out of 18 cases) and in my small number of observations there is about the same proportion.

The axillary glands become involved in the majority of cases, apparently with no relation to the situation of the diseased focus in the breast. There may be felt a definite thickened cord stretching along the edge of the pectoral muscle to the axilla. When the glands are affected the disease very often seems to progress in them more rapidly than in the breast, leading to softening and breaking down. In some cases the breast is secondarily affected to the axillary lymphatics, and so the history should carefully ascertain the part first involved.

Diagnosis.—In cases of primary tuberculous disease of the breast, with the skin sound, the diagnosis may be very difficult. Take care to exclude other cases giving rise to sinuses, etc., as submammary abscess due to rib necrosis or to pointing empyema. Those cases where there are one or more fistulous openings discharging a curdy pus, and perhaps a history of tubercle in family, or showing other lesions, give no difficulty. The diagnosis has to be made from:—

1. *Chronic Suppurative Mastitis.*—This is not easy where the case is primary. In the tubercle we should not expect such a definite outline, and when there is an opening the pus should be curdy, not thick and yellow. Astley Cooper gave as a point of distinction the absence of tenderness, but in four of the cases that have come under my notice this has been rather a prominent symptom. Pain when suppuration is taking place would be more marked in chronic mastitis. Enlargement of the axillary glands is a much more constant feature in tubercle,

and such, when present, are not so systematically tender as they are in cases of simple inflammation. Both of them have relation to lactation, so this is not of great assistance, but this unaccompanied by other signs favors mastitis.

2. *Chronic Interstitial Mastitis.*—In rare cases the tuberculous lesion may simulate this, as in the case quoted before. Here the breast was uniformly enlarged without any nodulation, and with a well-defined edge—in fact, characteristically "cake-like." But there were points which enabled the diagnosis of tubercle to be made, in that there was slight adhesion of the skin with localized tenderness. The former is not likely to be present in chronic diffuse interstitial mastitis unless there has been some former inflammatory trouble in the breast: and the latter symptom in chronic mastitis, if a feature at all, would only be present perhaps during menstruation. Enlargement of the axillary glands seemed quite confirmatory of tubercle.

From Carcinoma.—In some cases it so difficult that breasts have been removed on the above diagnosis. In the case of L. B., (Sir William MacCormac), the breast, the seat of an old abscess, became enlarged in the space of a few weeks, giving an isolated swelling, skin adherent with some pain, but no enlarged glands. Its acute development suggested cancer, and accordingly the breast was amputated; but to the naked eye on section it was evidently a chronic suppurative mastitis, and on histological investigation it proved to be tubercle. Réclus quotes the following to prove the difficulty:—

1. A woman, age 40, with a tumor the size of an egg, without any definite margin. It had a bossy surface, and was of woodeny hardness. The skin was involved and puckered, and the axillary glands were enlarged. So certain was the diagnosis of cancer from these facts, that the operation had been fixed, when a sudden hæmoptysis took place: the tumor itself later on softening, with discharge of curdy pus.

2. After weaning three years before, a tumor formed in the outer part of the breast, bossy and infiltrating. During the next pregnancy it increased in size, but quite painless. There was no fluctuation; the skin was puckered and the axillary glands were enlarged. This appeared to be a carcinoma, but, on going into the history, she had had hæmoptysis. Her age—30—suggested the possibility of tubercle, which was confirmed by an examination of the apices, and, on inquiry, history of hæmoptysis was obtained.

3. Dubar describes a case for diagnosis. The woman, age 23, was strumous. Ten months after weaning, a lump, the size of an almond, was discovered at the upper and outer part of the breast. This increased in size, and the nipple became retracted and the skin adherent. From her strumous appearance, tubercle was considered, and, on incision into this mass, the curdy pus was set free.

In none of these three cases was there any fluctuation. On the other hand, Habermass had a case which he considered tubercle, but on section it proved to be a case of multiple softening cancer.

NEWSPAPER COPYRIGHT.

The proceedings taken recently by the proprietors of the *Times* to assert their proprietary rights in copyright matter appearing in their newspaper has had the effect of eliciting from the judge who heard the cause a very important declaration as to the effect of the law upon this subject. There has gradually grown up a system of newspaper production by quotation which has received some very striking developments in recent times, and it is not unnatural that those who bear the cost of providing original matter should become increasingly desirous of monopolizing as far as possible the commercial fruit of their enterprise. At the

same time, it is easy to see that where current news is in question, this definition of a satisfactory copyright becomes exceedingly difficult. It was accordingly upon those parts of the *Times* case which related to paragraphs of this description that the counsel who appeared for the *St. James's Gazette* took their stand. Plainly the mere accident of being first to learn and publish a fact cannot be permitted to give to its publisher the right to forbid anybody else from communicating the fact, whether by print or otherwise. Inasmuch as in current news the fact is commonly everything, the literary form a matter of small or no account, it seems idle to assert a copyright in matter of this description. But Mr. Justice North did not dispose of the matter in any rough-and-ready manner of this sort. He held that the plaintiffs were entitled to a copyright even in short paragraphs of news, but he took care to discourage litigation based upon any such minute grounds of complaint as the infringment of such rights could furnish by refusing the plaintiffs costs so far as these particular matters were concerned. Probably a right recognized in law, but in practice fettered by the risk of incurring incommensurately heavy costs is the best practical solution of the difficulty.—*Lancet.*

HÆMORRHAGE INTO BURSÆ.

Upon this subject Dr. Lucy, of Plymouth, writes to the *Lancet*:

Hæmorrhages and sudden serous effusion into the cavities of bursæ have not received much notice or the attention they deserve. Hæmorrhage into a bursa is traumatic in origin, and may follow (*a*) contusion or (*b*) severe and sudden movement of a joint over which the bursa is situated. The sacs most liable to this injury are, in order of frequency, (1) the two pre-patellar, subcutaneous and subfascial; (2) that over the olecranon process; (3) that over the tuber ischii; and (4) the subacromial bursa. The position of these over bony surfaces or "points" favor the production of this condition.

In support of these statements I append the following cases as typical of the two chief causes:—1. An old man, aged seventy, a month before coming under notice fell and struck his buttock. A swelling over the right tuber ischii quickly appeared, which has remained the same size, the skin over it now being red and œdematous. On incision the tumor was seen to consist of a glistening cavity lined with blood-clot, which was turned out and drainage established. It would not close, so the bursa was excised, and the patient made a good recovery. (2) A coalheaver, aged forty, when lifting a weight, felt a "click" in the right elbow, and found a soft swelling at the point of the elbow. This "hardened" on the way up to the London Hospital, and on admission I found a tense, painless swelling in the situation of the olecranon bursa, which on palpation was found to contain clot. The history here was so circumstantial that I regarded it as a case of hæmorrhage into a bursa following exertion. In a similar manner a fall on, or the impact of a falling body on, the point of the shoulder causes the subacromial bursa to fill; subsequent crackling on active or passive movement has led to the diagnosis of "fractured anatomical neck," etc.

Signs and Symptoms —The subject of hæmorrhage is important because the signs accompanying the presence of blood in bursal sacs are those which would lead us to confidently expect pus, and I have seen many cases of enlarged bursæ treated by incision when the sole contents were blood in various states of change, or merely serum more or less blood-stained. Following a blow, fall, or severe strain, a swelling appears in the anatomical position of a bursa; this enlargement comes on rapidly—usually in a few minutes—and the patients tell you that the lump has been "the same size every since the fall, etc.," a most important point

in the history. On palpation fluctuation is readily obtained with a certain amount of pain and tenderness, especially when caused by contusion; in a few days redness and œdema of the skin over and round the bursa appear, and we have the classical cardinal signs of inflammation ("tumor, dolor, rubor, calor") present, but as we shall afterwards see, not pus but "cruor." The thermometer is here our best, though not an infallible, aid. In hæmorrhage pure and simple, although the signs of suppuration appear so unequivocal, we find the temperature rarely above normal. Relying on signs alone, I have seen many bursæ opened as abscesses, to find nothing but blood-clot or serum, with, in some cases, such as the pre-patellar bursæ, thin pus in the subcutaneous, but blood-clot only in the thick-walled subfascial, cavity, analogous to the so called "reflex abscesses" outside a joint the seat of commencing disease. It is in these cases that ecchymosis is not present; when it is, no doubt exists as to what composes the tumor contents. Crackling or rubbing is a sign especially marked on palpating a subacromial bursa filled with blood-clot. The so-called "melon-seed bodies," so often to be demonstrated by palpation at the bottom of such bursæ as the olecranon and pre-patella, are, I take it, evidences of former hæmorrhage, being composed of condensed decolorized (more or less) fibrin, either free in the cavity or moored by a longer or shorter pedicle to the interior; occasionally they are fixed and sessile. My object in calling attention to these points is to prevent bursæ being needlessly opened, for tedious suppuration almost invariably follows and the bursa has to be excised.

Treatment.—The limb should be immobilized on a splint, an ice-bag or evaporating lotion applied, and rest of the joint ensured for several weeks if the patient be anæmic or tubercular, in order to prevent suppuration. The swelling slowly subsides, leaving "melon-seed bodies" behind, and these seem to be the starting point of the hæmorrhage following exertion. That hæmorrhage into bursæ is more common than it is supposed is proved by finding broken-down clot in the contents of abscesses caused by the bursting of a suppurating bursa into the subcutaneous tissues—e. g., round the knee-joint.

INFLAMMATION.

In a lecture upon the important subject (*Brit. Med. Jour.*) Dr. Leber, of Heidelberg, says concerning the local process which goes on in and around an inflamed area:

The occurrence of necrosis within the microbic area and in its immediate neighborhood, and of inflammation at a distance, is to be explained by the supposition that at this distance the injurious substances are not sufficiently concentrated to cause death, but only to produce those changes in the vessels and their contents on which inflammation depends. The dilatation of small veins and capillaries in inflammation may be regarded as the result of a toxic paralysis of the cells of the vessel walls, causing loss of their tone, and an inability to resist the pressure of the blood. Upon widening and greater permeability of the vessels, together with the slackened circulation, depends also the increase of the transudation of the plasma, which regularly occurs in inflammation. The emigration of the leucocytes, on the contrary, is not to be regarded as a purely passive process. They are not simply pressed through the spaces in the vessel walls, but pass through by means of their amœboid movements, after first lining the inner surface of the vessel wall. Concentration of the injurious substance causes a paralysis of the cells, and its dilution exercises a stimulating action, causing the cells to direct their movements towards the point of the great concentration. Under any other supposition it is impossible to understand why the cells press forward so densely in the neighbor-

hood of the microbes; and how they manage to overcome such obstacles to their movements as present themselves. This theory is confirmed by direct observation.

Influences of the same kind as we have assumed in the movements of the leucocytes are active also in many other cells of very different character, as well in animals as in plants. The botanists have given to this process the name chemotaxis. Very similar to the chemotaxis of leucocytes is that observed in one-celled organisms, as in certain bacteria, whose movements in a fluid are excited through appropriate food substances, so that they are allured in great numbers to the food material; whilst other substances and even too strong a concentration of the blood material have a repelling action.

As to the mode in which the accumulation of the leucocytes can be of benefit to the damaged tissues, we must first mention their ability to take up into their substance, and remove, all finely divided foreign bodies. By this means they are able to free the organism from all intruding substances. The liver is the chief deposit of these cells laden with foreign bodies, which are there distinguished, or in other ways rendered harmless.

Recent investigations show that the power of the body to kill micro-organisms, or to render them harmless, is not the property of the leucocytes alone: the blood and other tissues or fluids possess this power in a still higher degree.

It is true that in the blood the leucocytes are numerous, but in the normal tissues they are far too scarce to take up in a short time any considerable quantity of matter. This we see when we inject finely powdered cinnabar into the anterior chamber of the eye of an animal. Introduce a considerable quantity of this pigment, and you will find that only a slight hyperæmia, but a very profuse migration of leucocytes into the chamber, takes place, and that the cinnabar is taken up by the leucocytes, which soon will wander into the neighboring tissues, especially into the iris and ciliary body. It is plain, therefore, that cinnabar, which has always been regarded as a completely insoluble and chemically inert substance, exercises a certain action upon the vessels which is doubtless of a chemical nature. From this and other experiments, the conclusion must be drawn that insolubility in the strictest sense of the word does not here exist, but only a great difficulty of solution. If we introduce the cinnabar at the bottom of a little tube into the anterior chamber, it causes a migration of pus cells into the lumen of the tube similar to that produced by quicksilver, only in smaller quantity, affording certain proof that its action depends upon the solution of a minute quantity of the substance. A smaller but still positive action is seen when the glass tube contains one of the nobler metals, as gold or platinum, in a finely powdered state. I have been unable as yet to find any single substance which, when introduced into the anterior chamber, proved itself to be absolutely inert, not even excepting those substances which are considered by chemists to be completely insoluble, for example, sulphate of baryta, crystallized silicic acid, and pure carbon. Especially striking is the proportionately strong action produced by the introduction of chemically pure carbon carefully obtained from graphite.

There is still another property of the leucocytes to which I would draw attention, namely, the power to soften and finally to throw off organic substances, especially dead portions of the body. This softening is to be attributed to the action of a ferment which must be produced by the leucocytes and not by the micro-organisms. Although certain positive results have been obtained, this tissue-softening ferment has not yet been isolated. It is, however, possible to demonstrate that leucocytes alone, in the entire absence of micro-organisms, have the power of softening and dissolving the tissues. The processes in the tissues and

organs of the body which are caused by the action of foreign substances are, as we have seen, most numerous and complicated; and especially so because all these various processes occur and act in unison. They vary in their nature and degree with the influence of the external injury, all the processes having the character in common of being directed towards the attainment of a definite object. Thus, inflammation is to be looked upon as a conflict which the organism maintains against the injurious influences from without.

DEATH FROM HEART-CLOT IN THE EARLY PERIOD OF PNEUMONIA.

Dr. Conkling gives a very suggestive paper on this important subject in the *Brooklyn Medical Journal* for September. In defending his views before the Kings County Medical Society he compares the slow descent of the typhoid fever patient with the sudden death of acute pneumonia.

Of the latter he says: Here is a case of lobar pneumonia at the eighth day. The pulse is rapid. To each beat is added an element of irritable "quickness." The heart sounds are peculiar, the respirations are panting; but the eye is bright, the mind is clear. Even as you stand by the bedside of the patient there may be a tremendous heave of the thoracic walls, the hand clutches the neck, every movement is to gain air or blood in the lungs, something to sustain life, and then with a sudden jerk the head falls forward, chin on sternum, and the man is dead.

Is there any similarity whatever in the manner of death in the two cases? You may say that the fever man's heart caused death. You call it asthenia, and you prove it in the dead-house. You cannot call the pneumonia man's heart asthenic, nor can you prove it in the dead-house. If you have an ante-mortem cause of death in one case, you must have it in the other. The post-mortem will find the fever heart's tissue weak, flabby, friable, degenerated, tearing like blotting paper, while the pneumonia heart is of good color, with muscular fibre toned up to the highest pitch of intense activity. There is no weakness there. You find in it a heart-clot. You call it ante-mortem for three reasons. First, because the patient has died just as patients must die with circulatory obstruction. Second, because of the formation and the disease. Third, because the organs closely related to the heart in the way of blood supply are in the condition which comes from mechanical disturbance in circulation.

There is but one way in which to make conclusive this evidence. This is by the clinical study of the heart in lobar pneumonia. This means that the heart must be examined in every case constantly many times, whenever the patient is seen.

Take for instance a hospital ward in which there are, say, fourteen beds. There is one case of labor pneumonia. In the other beds are patients with various acute diseases. You make a painstaking, careful, systematic examination of the pneumonia heart. Record what you find. Go to thirteen other beds and examine thirteen other hearts, and not in a single instance will you find what you have heard in the heart of pneumonia. Your patient dies. You find on post-mortem examination a heart-clot. Record its position and see if it corresponds with your clinical notes. You have other cases of pneumonia. You examine their hearts, comparing the findings with the examinations of other hearts. You have no duplication. There are certain definite, peculiar signs. I have mentioned them in the paper. When they occur, you find on post-mortem examination a clot, accounting for their presence. Your clinical cases will outnumber your post-mortem examinations, but still you have enough to prove that you have an ante-mortem cause of death in an ante-mortem heart-clot.

THE DIFFICULTY IN DIAGNOSIS OF VARIOLA.

In the discussion of a paper read by Dr. Wetzel before the Denver Medical Association and Arapahoe County Medical Society, Dr. Taylor (*Denver Medical Times* for September) remarked:

The difficulty in making a diagnosis of small-pox is considerable even when there is variola about. I do not believe there is any safety in making a positive diagnosis until the eruption comes out. Sporadic cases are the difficult ones to diagnose. The tendency is strong in these cases to make an early diagnosis. Of twenty such cases reported a different diagnosis had been made in all. In cities we can never tell whether a patient has or has not been exposed. Four years ago, while in attendance at a skin clinic in New York City, a patient presented himself with four pustules on the face which were characteristic small-pox pustules. He felt well and had been at his usual avocation of peddling. In this case there is no telling how many families had been exposed.

I think we all fail in watching our patients concerning vaccination. In Germany every child must be vaccinated before September of the year following its birth. Again, if we fail in vaccination after one or two trials, we give it up. I have had an amusing experience in this respect. A deaf mute was brought to me to be vaccinated, as she was to be sent to an asylum, and they required thorough vaccination before admittance. She had often been vaccinated without effect, and I vaccinated her with fresh virus three times and none of it took. I concluded she was one that would not react to the virus, and I wrote a letter to the superintendent of the asylum stating that I had carefully vaccinated her and that I did not believe more could be done. Just before she started off, however, I vaccinated her again and was very much surprised to get a good reaction and a fine scar.

TREATMENT OF TRANSVERSE PRESENTATION BY INVERSION OF THE BODY.

In an article by Dr. Barnum, of New York State (*Buffalo Medical and Surgical Journal*) is a description of a case so graphic in its outlines that it bears a second-hand quotation from the pages of the *Virginia Medical Monthly*, of September. Dr. Barnum says, in part:

We renewed the attempt to perform version and again failed, on account of the firmness with which the shoulder and side of the head were jammed down upon, or just within, the pelvic brim. All attempts to replace the prolapsed arm also failed, on account of the tetanic contraction of the uterus upon its contents. The force with which the shoulder was crowded into the superior strait is shown by the fact that several months elapsed before the child could move that arm as freely as its fellow. Neither Cæsarean section nor embryotomy was practicable in this case. The former operation would almost necessarily have caused the death of the mother. Instruments for the latter operation could not be procured in time to be of service. In this emergency, Dr. Barnum determined to try a method, which, so far as he knew, had never been recommended in the treatment of transverse presentations.

The woman was placed in a knee-chest position upon the bed, when we again attempted to push back the fœtus, hoping either to replace the arm and get a vertex presentation, or else to perform podalic version; but so firmly was the fœtus held in position, that we again failed. Dr. Barnum next brought the patient on her knees to the edge of the bed, with a strong assistant at each side. Her head was slowly lowered until her position was nearly inverted—her head almost touching the floor. Then compelling her to breath rapidly, to pre-

vent her "bearing down" involuntarily during her pains, we soon began to feel the gradual withdrawal of the fœtus from the superior strait. Within a very few minutes—probably not more than five—we were able to replace the arm. With the next pain the head presented by spontaneous version. The patient was directed to "bear down hard," and was placed in bed; the descent of the arm was prevented by means of a finger in vagina. Labor proceeded rapidly, and within fifteen or twenty minutes the child was born *alive*.

SECONDARY HÆMORRHAGE FROM ENUCLEATION OF EYE, FOLLOWED BY RESTORATION OF SENSE OF SMELL AND TASTE.

At the June meeting of the North Texas Medical Association, Dr. Becton, of Sulphur Springs, related (*Virginia Med. Monthly*, September) the following history, given him by a patient whom he vouches for as "a Scotchman by birth, a lawyer by profession and a truthful gentleman."

"On the 8th of November, 1880 (I was then 30 years of age), I was accidentally kicked by a horse. The blow was received on the right side of the head, on and above the cheek bone, cutting into the eye socket on the outer side. Unconsciousness so closely followed the injury that I was not aware of my hurt until the fifth day after, when I found myself quite blind; the muscles of the face so paralyzed that, for about three weeks, when sight returned in a slight degree in the left eye, it was necessary to lift the eyelid with the finger to see at all. The right eye was sightless and remained so. The eye-ball gradually shrank to one-half its natural size. The attending physician, Dr. L. J. Graham, expected me to die the night after the injury.

"About seven weeks after the injury, I noticed a gradual decline in the senses of taste and smell. These defects finally became so positive that I could hardly distinguish the strongest odors, and was only aware of an agreeable degree of bitterness in quinine dissolved in water.

"Ten and one-half years after the date of the injury, I was attacked with sympathetic inflammation in the left eye. I consulted Dr. E. P. Becton, of Sulphur Springs, who advised the immediate removal of the injured eye. He performed the operation the next day, April 28th, 1891. I was able to leave my bed and walk down stairs on the second day after the operation, feeling quite well under the circumstances.

"On the fifth day, I walked to the barber shop and drug store, returned to the hotel, and, while sitting at the supper table, was attacked with a very severe hæmorrhage. Indeed, I thought for half an hour I might die, so great was the loss of blood. Upon the arrival of the doctor the hæmorrhage was checked, and, with good nursing, I recovered in a few days.

"On the next day after the hæmorrhage, my kind nurse laid a bunch of flowers on the pillow, near my face, and I was surprised to find that the sense of smell had returned, so I could enjoy the perfume almost as well as before the original injury.

"I also found the sense of taste surprisingly acute, and I enjoyed the food given me for breakfast as I had not done before since the date of the injury, all of which was very gratifying to me. Up to the present date (June 1st, 1892) these faculties still remain perfect."

METHYL-BLUE

The following is from an article by Dr. Boggers in the *Amer. Practitioner and News*, of Aug. 27th:

A year or so ago some progressive Eastern surgeons and pathologists began the

use of some of the aniline colors upon morbid growths. The pyoktanin, blue and yellow, and fuchsin were employed, both topically and as injections into diseased tissue. Old chronic ulcers, rapidly proliferating epithelial growth, pus-secreting cavities, and other foul surfaces were found to do well under the proper use of pyoktanin. Our dye specialists, I believe, now use the yellow pyoktanin.

In the spring of 1891, while attending physician to the German Protestant Orphan Asylum, in which we have from ninety to one hundred and ten little ones, we had a siege of diphtheria which ran through the whole institution in spite of all the prophylactic measures we could adopt. Out of the first five cases, following the old line of treatment, we lost three cases. Yet considering the virulence of the epidemic I considered myself fortunate to save two. In desperation I began to search for something new, knowing that the Krebs-Loefler bacillus was most readily stained by methyl-blue dye, and that it was both antiseptic and astringent. I determined to try it locally, which I did in the strength of one to eight. I found considerable relief given the patients. At this time I called Dr. J. B. Marvin in consultation, and he suggested that the drug be given internally, as it was non-toxic, save in large doses, and the toxic symptoms were then due to the arsenic and zinc which it contained as impurities. I began giving it in two-grain doses every two or three hours. What the action in diphtheria is I am unable to state, save in fifty-two consecutive cases treated in the asylums and in private practice I never lost a case. All these cases were beyond the possibility of mistaken diagnosis. After giving one single dose of the drug, in two hours the urine became very blue (showing rapid dissemination and elimination of the drug), and would remain so for five or six days afterward—specific gravity 1016–1021; no albumen, no casts, no epithelia, an increase in quantity of urine, without any evidence at all of kidney irritation.

Observing this action upon the kidneys, I resolved to try it as a diuretic in certain marked renal conditions. I was called in consultation to see O. H., a paralytic from myelitis of some seven years' standing. He was seemingly passing rapidly *in articulum mortis*. Had been doctored for some time for bladder trouble; was passing from eight to twelve ounces of urine, half of which was pus, per day. There was pain in lumbar region just before this minimum discharge of pus; a tumor at seat of pain; epithelium from pelvis of kidney and infundibula; blood globules; mucus; every indication of an extensive pyo-nephrosis, loss of appetite, and rapid emaciation. I immediately put this patient on two-grain doses of methyl-blue every three hours, and in a very short while marked improvement was noticed, until now, six months afterward, patient is passing three pints of urine, in which only at rare intervals can any pus be found. He has regained his appetite, has gained fifty pounds in flesh, and is in better health than for years. He continues to praise his doctor, and take methyl-blue.

Medical Items.

The British Medical Association has decided almost unanimously in favor of the admission of women into the society.

A noted French physician claims to have got good results in goitre from tincture of strophanthus ten to sixteen drops three times a day.

Dr. W. P. E. Wyse, Surgeon of the Confederate Home, who has been dangerously ill at his home, in Pikesville, is now convalescent.

Drs. Thomas Opie and Thomas S. Latimer, who have been spending their vacation abroad, have arrived in Baltimore, both being passengers on the steamer Aurania.

Dr. Karl Von Ruck's Sanitarium, "Hotel Belmont," at Ashville, N. C., was destroyed by fire during the latter part of August. About 175 guests and patients were in the building at the time the fire began, and many of them made narrow escapes. When Dr. Von Ruck can make satisfactory arrangements for another building, etc., he will announce the fact.—*Virginia Medical Monthly.*

The pharmacists of Danville, Va., have made a good move in determining among themselves to keep one store open in rotation on Sunday—all others of the city being kept closed except for two hours in the morning and two hours in the evening of that day. This allows the drug clerks much needed rest, and yet amply supplies all the demands of those who may need medicines.

Sir Edwin doesn't mind it.—An expert in cholera, Sir Edwin Arnold, says cholera is "a disease of dirt and cowardice." It is not a thing for a healthy person to fear. "Drink," he says "no milk or water that has not been boiled, scald your vegetables and take five drops of hydrochloric acid in half a cup of hot tea and you can walk unharmed in the midst of cholera." Cold weather, he asserts, will check the disease. Sir Edwin's experience in India, the home of cholera, enables him to be more cheerful about it than Americans know how to be.—*Sun.*

A law to suppress tuberculosis, especially in milch cows, was enacted by the last New York legislature. In general, the law authorizes the health inspectors to examine all the cattle in the State, and, when the disease is found, to cause the animal to be killed. The owner will be reimbursed for the actual value of the cow. The plan of carrying on this inspection has not been decided upon. An appropriation of only $5,000 has been made for the purpose. The dairy statistics of the State show that milk production is the largest industry in the State, and that it is greater than that of the milk production of all the other States put together. There are 11,600,000 milch cows in the State. The farmers sell to New York City $11,500,000 worth of milk, and to the people of the whole State $40,000,000 worth.—*Ex.*

The existance of cholera in the United States either this year or next would prove disastrous to the World's Fair. This result would be fatal if the impression became general that the water supply of Chicago was infected, no matter what the facts might be. The prevalence of typhoid in Chicago is already a matter of general knowledge, and its connection with impure water has been stated over and over again in the medical journals. The *Journal of the American Medical Association*, which is published in Chicago, says in its issue of July 23rd: "That it should be necessary, month after month, to boil and filter every pint of water that is used for drinking purposes in a city of more than a million of inhabitants is a scandal of monumental proportions upon the city government." A friend who passed the last year in Chicago informs us that the water left standing in pitchers over night is so offensive that it cannot be used. The failure of Congress to pass an appropriation would not have been so serious a blow by half to the success of the Fair as the continuance of the present condition of the city's water supply.—*Brooklyn Medical Journal.*

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CONTENTS

ORIGINAL ARTICLES.

The Weight of the Body in its Relation to the Pathology and Treatment of Club-Foot. By A. B. Judson, M. D., of New York. . . 1035

Effects of Altitude. By Aluard White, M. D., El Paso, Texas. 1043

EDITORIAL.

How They Treated Cholera in 1832. . . 1047

The Cause of Enteric Fever. . . . 1049

MEDICAL PROGRESS.

Dr. Brouardel on "Submersion."—Reflex Pain.—Nebraska Typhoid.—The New Formation of Bone.—One of the Sources of Danger in Chloroform Anæsthesia.—Southern Wit. . 1049

CORRESPONDENCE. 1052

THERAPEUTIC RECOMMENDATIONS. . . . 1055

MEDICAL ITEMS. 1056

Original Articles.

THE WEIGHT OF THE BODY IN ITS RELATION TO THE PATHOLOGY AND TREATMENT OF CLUB-FOOT.*

BY A. B. JUDSON, M. D.,

Orthopædic Surgeon to the Out-Patient Department of the New York Hospital.

I desire to present a few thoughts, of an extremely practical kind, relating to the treatment of talipes equino-varus. Beginning with congenital club-foot, it is well to bear in mind that there is a vast difference between a child recumbent and a child walking. While the child is in arms the case is yet free from the complications and difficulties caused by the falling of the weight of the body on the deformed foot. These twelve months, more or less, are the most important year in the history of the case, because, in this period, the foot is to be changed so that, when the child begins to walk, the use of a slight walking-brace, exerting only a moderate degree of force, will convert the weight of the body from a deforming to a correcting agent. During these months of recumbency, with the weight of the body out of the way, with all the tissues soft and formative, and the foot more than doubling in size with the growth of the child, there is every reason to expect to succeed in what we undertake, provided time enough be given to the case, and faithful attention to the details.

*Read before the American Orthopædic Association, New York, September 21, 1892.

The apparatus which I have conveniently used to effect this reduction, before the child learns to stand, is a simple retentive splint which acts as a lever, making pressure on the outer side of the foot and ankle, at A, in Figs. 1 to 4, inclusive, and counter-pressure at two points, one on the inner side of the leg, at B, and the other at the inner part of the foot, at C. It is advisable to keep in mind that this simple instrument is a lever, because, if we know that we are using a lever, with its three well-defined points of pressure, we can make the apparatus more efficient than if we view it, in a more general way, as an apparatus for giving a better shape to the foot.

Fig 1.

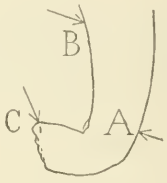

Fig. 2.

Fig. 3.

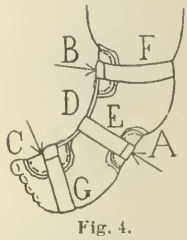

Fig. 4.

I use a little brace made of sheet brass, doing the work with a few simple tools. An advantage of doing the work one's self is that there is no room for doubt as to where the blame lies, if the apparatus does not work well. Two curved disks, B and C, Figs. 3 and 4, are riveted to a shank, D, and thus is formed that part of the brace which applies the two points of counter-pressure, while, on the other hand, the point of pressure is brought into action by a third disk, or shield, A, which is drawn tightly against the other side of the foot and ankle, and held in place by a strip of adhesive plaster, E, which includes the limb and the piece which connects the two disks, B and C. The disks are lined with two or three thicknesses of blanket, easily renewed, when necessary, with a needle and thread. These braces are so cheap and easily knocked together that it is nothing to apply new and larger ones, using heavier material for the shank as the child grows. In general, three sizes will be enough, the shanks being 12 gage $\frac{3}{8}$ inch wide, and 14 gage $\frac{1}{2}$ inch wide, and 16 gage $\frac{5}{8}$ inch wide. The disks are conveniently made from 22 gage $1\frac{1}{4}$ inch wide. The rivets are copper belt rivets No. 13. A lip turned on the edges of the disks, with the flat pliers, gives stiffness to the thin brass and protects the skin from the rough edge. If more easily obtained, tin disks, light bars of iron or steel, and ordinary iron rivets, would doubtless answer.

The brace is applied with three strips of adhesive plaster. The upper and lower pieces, F and G, Fig. 4, are simply to keep the apparatus in place, which they do effectively if ordinary gum plaster is used, while, by drawing the middle strip, E, tightly over the shield, and straightening the brace from time to time, the deformity is gradually and gently reduced. At each reapplication the brace is made a little straighter than the foot at that stage. This may rapidly be done by the hands, and then the adhesive strip is to be tightened over the shield, till the shape of the foot agrees with that of the brace. After a few days, the brace is to be made still straighter, and again re-applied, and made tight until another

point of improvement is gained. The brace is applied very crooked at the beginning of the treatment, as in Figs. 3 and 4, and is straightened from time to time, and a longer brace applied as the deformity is reduced and the patient grows. It should be removed every week, or two weeks, and an interval of a few days allowed for freedom from the brace, when the mother is advised to manipulate the foot constantly, using as much force as she will in the direction of symmetry. Manipulating the foot during these intervals is of great importance, as cases have occurred in which varus and equinus have been entirely overcome by the mother's hand alone.

Fig. 5.

Fig. 6.

Fig. 7.

Fig. 8.

By this simple and prosy treatment, carried out systematically and without haste, or violence, or pain, the foot, unless it is a frightful exception, may, with certainty, be changed from varus to valgus. At the same time, the tendo Achillis is lengthened till the position of the foot is near the norm, or at right angles with the leg, as the result of manipulation, and giving the brace from time to time a partly antero-posterior action. Figs. 3 and 4 show approximately the shape of the brace at the beginning of treatment, Figs. 5 and 6 when the varus is reduced, and Figs. 7 and 8 when valgus has taken the place of varus. The foot, in this latter stage, may not hold itself valgus, when left to itself, but, with almost no force, and with one finger, it may be pushed into valgus; and in this condition it must be when the child begins to walk, and then another stage of treatment begins.

When the patient begins to walk we have a new difficulty. It is now seen that the weight of the body, falling on the tender and ill-formed foot, will, if not properly directed, defeat all our efforts. Let us, for a moment, consider the mechanical environment of the human foot. In the first place, the corporal weight, which the quadruped distributes among four pedal extremities, falls, in man, upon two. Again, the small floor area covered by the feet, and their slight structure, seems unequal to the task of supporting the towering frame above them, which in some cases almost resembles a pyramid resting on its apex. And when we observe the effect of active locomotion we see weight and momentum combine in an apparent effort to crush and destroy. And furthermore, when extraneous weights are added and the strain is prolonged, as in the case of the burden-bearer among savage tribes, or the infantry soldier on a forced march, the endurance of the foot excites wonder. It is not strange that the feet are subject to ailments: to blisters, bunions, ingrowing nails, hallux valgus, hammer toes, loss

of the arch, weak ankles, painful affections of the metatarsus, perforating ulcers, osteitis, and the varieties of talipes. The wonder is that they are not permanently disabled soon after walking is begun, and certainly when the adipose tissue of the body takes on the development which accompanies age and good living. The gourmand, Savarin, said that, among the works of creation, the design of the human foot was a conspicuous failure. Considering the immense weight carried by the foot, it is evident, however, that only the most perfect natural adaptation of mechanics has enabled this insignificant member to perform its superlative functions, and that great caution should attend all procedures having for their object its artificial re-construction.

It is also sufficiently evident that the correction of club-foot by mechanical means, while the patient continues walking, is a problem beset with difficulty. We have, however, a luminous ray of hope and encouragement in his observation that, in talipes varus, there is an important boundary between deformity and the norm. If the foot is held in some way, now to be considered, on the right side of this boundary line, each step forces it in the direction of valgus, and the increasing weight of the child is a powerful force acting in the right direction, or away from varus, so long as the foot is held, though never so little, looking toward symmetry. It may be said that a child stamps his foot straight. If, on the other hand, the foot is held, or allowed to fall, on the wrong side of the line, though never so little, each foot-step is a blow, driving the foot more and more into the varous position.

The point may be illustrated by the hand placed with its ulnar border on the table. If considerable pressure be made on the table, by the hand so placed, it becomes evident that there is a boundary line between pronation and supination. If the hand is pronated, never so little, additional pressure will force the palm into pronation, which represents valgus in the foot, and if the hand be supinated in the slightest degree, additional pressure will force the palm into complete supination, which represents varus in the foot.

By the application of this idea, the weight of the body may be made a beneficent, instead of a harmful, factor in the progress of a case of talipes varus, and the walking brace should be constructed with this in view. It should be made of steel and by an instrument-maker. One of its functions is to act as a lever, but the leverage is applied not chiefly to overcome the deformity by direct force, as in the retentive brace above described, but to hold the foot on the right side of the boundary line above mentioned, so that the weight of the body may straighten the foot, or overcome the varus in a direct and forcible manner, without general or local inconvenience.

The walking brace consists, as usual, of leg-band, H, Figs. 9 and 10, foot-piece, I, and upright, J, riveted firmly together. A movable joint at the ankle should be discarded, as it undermines the lever by introducing an element of instability and, in this brace, serves no good purpose. Mild steel alone should be used, to facilitate alterations in shape, as point after point of improvement is gained, and to make

easy the shifting of buckles and straps, as may be required, all of which may be done by the use of a few simple tools. The upright is to be on the inner side of the leg, as in Fig. 14. The upper part of the brace makes counter-pressure on the inner side of the leg, but it has another important function, in previously neglected cases, which is secured by the steel band passing across the back of the leg, to which are fastened two buckles for the attachment of a piece of webbing, K, in Fig. 9, which passes across the front of the leg. The steel band should make no pressure on the limb, as its use is simply to furnish attachment to the buckles. A piece of webbing spanning the front of the leg in this manner and carrying a pad, performs an important service in cases, like the one shown in figure 12, in which, from previous neglect, the varus has not been reduced before walking begins. It takes part of the body-weight from the anterior part of the sole of the foot, where it interferes with the correction of the varus, to the upper part of the anterior surface of the leg, where it is powerless to interfere with the treatment. That the weight-pressure thus transferred is considerable, is shown by the callus and bursa which appears where the padded strap crosses the leg near the tubercle of the tibia. This mechanical effect is similar to that of the brace, shown in Fig. 11, used in the treatment of paralysis of the muscles of the calf, resulting in talipes calcaneus.

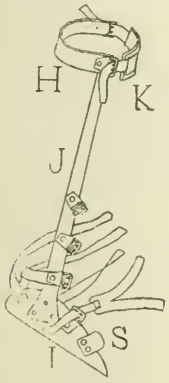

Fig. 9.

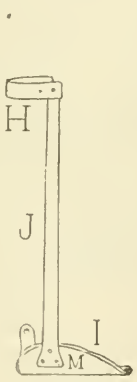

Fig. 10.

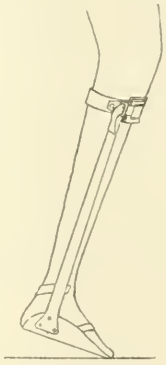
Fig. 11.

Fig. 12.

The upper part of the brace is also to be considered in another light, as follows: In previously neglected cases it is well to incline the upright 15°, or 20°, or more, backward from the vertical of the foot-piece, as is shown in Fig. 9. Although correction of the equinus is postponed by this inclination of the upright, we are thus enabled to apply a better leverage against the varus, and when the varus is reduced, and the time arrives when the equinus is to be corrected, this backward inclination of the upright is to be lessened from time to time, till the vertical is reached, as in Fig. 10, or till the upright has an inclination forward, allowing the corporal weight to fall more and more on the anterior part of the sole of the foot, and gradually lengthen the tendo Achillis. The vertical upright, Fig. 10, is to be applied at once to patients in whom the deformity has been corrected before walking begins.

We will now pass to a consideration of the other end of the brace, the foot-piece, which is to be made of sheet steel ranging from 18 gage, for a child learning to walk, to 13 gage for an adult. It has the usual tread, L, Fig. 13, and riser, M, Fig. 10. The heel-cup is formed by a piece of webbing, N, Fig. 13, passing behind the heel, from the lower part of the upright to a spur, O, Fig. 13, which projects upward from the back part of the outer border of the tread.

Viewing the apparatus again as a lever, for the forcible reduction of varus, in a previously neglected case, counter-pressure is made along the inner border of the foot, and on the upper part of the inner side of the leg, while pressure is made by one strap, or more than one, riveted and buckled to the foot-piece and the upright. But one strap is shown, P, in Figs. 13 and 14. This will be sufficient in the case of a child whose varus has been corrected before walking begins, but in a previously neglected patient in whom the varus has yet to be reduced while the child is active on his feet, two, three, or more straps may be added, as shown in Fig. 9, partly encircling the foot, ankle and leg, the positions of the buckles and the straps being where they will assist most efficiently in opposing the varus and holding the foot in the best position to receive the weight of the body. These parts of the apparatus may be shifted many times, with advantage, in the treatment of a given case of unusual difficulty, and, in addition, a most efficient agent for applying continuous pressure is found in a strip of adhesive plaster, Q, Fig. 14, sewed to a piece of webbing, R, the plaster partly encircling the foot and ankle, with a single tail, or two tails, as may be required, and the webbing being drawn tightly and buckled to the inner side of the riser. This device does more than simply increase the amount of pressure; it also keeps the heel down on the tread of the foot-piece, and, more important still, it gives the foot a rotation outward and thus directs the sole of the foot forcibly toward the ground, in the best position for making the weight of the body a corrective instead of a deforming force. The riser of the foot-piece may also, in previously neglected and difficult cases, carry an ear, S, Fig. 9, 13 and 14, made of sheet brass, which is to be bent downward over the first metatarso-phalangeal joint, to prevent the inner border of the foot from over-riding the edge of the riser. The foot-piece is to be lined with adhesive plaster, in several thicknesses if necessary, to prevent rust, and with two pieces of leather fastened to the tread, and a spur with copper rivets, as shown in Fig. 10. In practice the details demand as much attention as the principles of treatment. The brace is to be applied over the stocking, the strap, R, passing through a hole cut in the stocking, and is hidden by the patient's trousers and shoe.

We will now consider the upright of the brace. It is a flat, tapering bar of mild steel, and when first applied to a previously neglected case, such as is shown in Fig. 12, should have a curve resembling that of the varous foot. The bar, though sharply curved, as in Fig. 13, should, however, be somewhat straighter than the foot, when the latter is forced manually into its best position. The multiple straps, shown in Fig. 9, should then be buckled and tightened daily till the

continuous leverage has partly reduced the varus. The upright bar should then be somewhat straightened and another point of improvement be gained, the patient in the meantime following his ordinary pursuits without interruption. In due time the upright bar and the foot itself will both be straight, as seen in Figs. 15 and 16—in other words, the varus will be reduced. The upright should

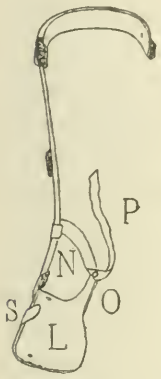

Fig. 13.

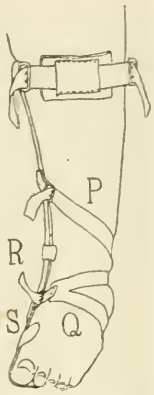

Fig. 14.

Fig. 15.

Fig. 16.

then be bent, from to time, in the direction of valgus, as seen in Fig. 17, and the persistent and gradual effort resumed until the foot has been pushed, or pulled or pried, over the boundary line, into the domain of valgus, as seen in Fig. 18. These efforts would not be necessary if the varus had been converted into valgus before the child had learned to stand. In very badly neglected cases the interference of the weight of the body with the treatment may be prevented by the recumbent position, or the use of a high sole on the well foot and the ischiatic or axillary crutch, until the varus has been materially reduced. In all cases, when the child is old enough to be docile, domestic instruction and drill in eversion of the foot, and in the proper management of the foot in locomotion, should be a part of the education.

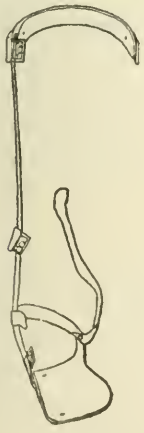
Fig. 17.

Fig. 18.

Fig. 19.

Fig. 20.

As soon as the foot has reached the valgous shape, whether it is at the moment of learning to walk, or only after prolonged effort, in a neglected case, a curious

effect will be observed. It will be seen that the outer border of the tread of the foot-piece is raised from the ground, as seen in Figs. 19 and 20, and that we have secured, in a convenient manner, the effect which is sometimes sought by building up the outer border of the sole of the patient's shoe. This is a welcome and powerful ally in our attempts to hold the foot in a favorable relation with the weight of the body and the ground.

The walking-brace has been above described as though its chief use were to reduce varus which has become more or less confirmed by the habit of walking on the outer border of the foot. Strictly speaking, such cases should never occur. They are, however, too common, and always indicate that the child has been neglected from the period of recumbent infancy, when deformity of this kind is the most easily overcome. If the varus were always corrected before the child learns to stand, then the only use of the walking brace would be, as shown in Figs. 19 and 20, to gently hold the foot in valgus, so that the weight of the body shall be sufficient to lead the child to grow up with the foot practically normal. As such a child outgrows the brace, a larger one is to be made, and, when three or four years old, the foot will, without the help of the brace, strike the ground so fairly that, for two or three years, all treatment may be suspended. The patient is to be observed from time to time, however, and, as the foot grows in its original inclination to varus, it will, after the lapse of two or three more years, have to be kept in proper position, under the rapidly increasing weight of the body, by a walking-brace adapted to its needs, for another period of two or three years. When the foot is full-grown it will be shapely in appearance and practically perfect in its ability to perform all the duty of a foot congenitally normal.

Although congenital club-foot has been chiefly kept in mind in the above pages, the views expressed in regard to the influence of the weight of the body are applicable also to talipes varus of paralytic origin. In this affection, at an early stage, and before the foot has lost its flexibility, a simple walking brace is needed, as in Figs. 19 and 20, to properly direct the action of the weight of the body on the paralyzed foot. At a later period, if this measure has been neglected, and the foot has been allowed to become varus, and more or less inflexible, the case will require more attention and probably prolonged effort, with multiple straps and adhesive plaster, to carry the foot across the line between deformity and the norm, to the position in which the weight of the body shall be a correcting and not a deforming force.

38 East 25th Street.

A writer in *Musical Millions* says he never loses time in looking for a fine vocalist in a country where fish and meat diet prevail. Vocal capacity disappears in families as they grow rich, because they eat more meat. Those Italians who eat the most fish (those of Naples and Genoa) have but few fine singers among them. The sweet voices are found in Irish women of the country but not of the towns. Norway is not a country of singers, because they eat too much fish; but Sweden is a country of grain and song. The carniverous birds croak; grain-eating birds sing.—*Ex.*

EFFECTS OF ALTITUDE.

BY ALCARD WHITE, M. D., EL PASO, TEXAS.

In studying the effects of altitude, it must be understood that the term is intended to imply much more than mere elevation above the sea level, with the consequent attenuation of the atmosphere. It implies, as well, a small degree of atmospheric humidity, a pure aseptic atmosphere, lessened barometric pressure, increased diathermancy, increased electrical tension, a relatively great variability of diurnal temperature, and a very low *dew point*. Hence, it must be borne in mind that in what follows all of the foregoing factors are embraced. As in the study of any other remedial measure, it is well to briefly glance at the outset at the effects of altitude on the healthy individual.

We note, first, a gradually increasing acceleration of the pulse and respiration as we ascend, which if carried far enough results finally in intense dyspnœa, cyanosis, and hæmorrhage from the nose, ears, etc. The acceleration of the pulse is due to the diminished barometric pressure, which, while it favors the action of the left heart, has a retarding influence on the return venous circulation. The increased frequency of respiration is due, primarily, to the attenuation of the atmosphere; to a certain extent, however, it undoubtedly results from the necessity that exists for this function of the body to keep pace with the heart in its more rapid movements, which requires increased respiratory effort for the proper oxygenation of the blood in its more rapid propulsion.

The only other primary effect of altitude that needs for our purpose to be mentioned is the increased cutaneous transpiration, which is the most permanent of any of the effects of altitude, and which results from the combined influences of well-filled cutaneous vessels, lowered tension, and the extreme dryness of the atmosphere; as a result of it the secretion of the kidneys is markedly diminished in quantity, and increased in specific gravity; it is likewise the most important factor in enabling the body to withstand the excessive heat that prevails at many places during certain months in the year; indeed, so great is this protective influence that sunstroke is unknown anywhere in the mountain region, although a temperature of 150° in the sun or 110° in the shade is not unusual.

Going back now to the effects upon the circulation and respiration, we note as secondary results that all processes of nutrition are quickened, the whole volume of blood makes the round of the circulation in much less time, and this, of course, implies a more rapid oxygenation, with increased activity of the processes of waste and repair, a stimulation of function of all the secretory organs, and marked exaggeration of nervous reflexes. In a word, the march of life in these altitudes is made in "quick time" as compared with the slow and dignified measure that marks this round of changes in lower regions.

I purposely omit discussing, at length, the effects of increased electrical tension, and lessened humidity; of the first of these I am not prepared to say what its effect is; all mention of it might just as well have been omitted, but for the fact that authorities have noted it; of the lessened humidity, it will suffice to say that,

as a result of it, the heat, light and actinic rays from the sun have unobstructed passage to the earth, that to it is due the marked variability of diurnal temperature, the freedom of the air from organic particles, the low dew-point and the great difference that there is between the temperature in the sunshine and in the shade, frequently amounting to 50 degrees.

Having thus briefly outlined the physiological effect of our remedy, altitude, we are in a position to deduce therefrom the benefits to be derived from its use in the diseased conditions. Grouping its effects, we feel fairly safe in styling the remedy a tonic alterative, in that it possesses the power of modifying deranged nutritive processes, of promoting appetite, digestion, secretion, absorption, and elimination; of counteracting the effects of various forms of toxæmia, as chronic malaria and tuberculosis, and promoting the absorption of inflammatory exudations. What, then, are the indications for its use? And when is it contra-indicated?

Commencing with the nervous system, we can see no special indications for its use, save possibly in those forms of paralysis that result from toxic influences, and in which the tendency of the disease is toward a return to health; indeed, even in these cases, it is easy to conceive a more rational method of treatment than to prescribe altitude, though it might well figure in the prescription as an adjuvant. Of course, in all forms of nervous disease in which there is even an intimation of exaggeration of function altitude is directly contra-indicated; not only is this theoretically true; clinical observation and experience confirm the conclusion. In the treatment of affections of the heart, either nervous or organic, it finds no place; since, as already shown, its effects are such as would aggravate rather than palliate any impairment of function, no matter what the cause or the character of the lesion, if one exists. The same may be said regarding diseased conditions of the bowels, liver, bladder, stomach and kidneys, for the reason that below the thorax the effect of altitude upon the venous circulation is retarding, the consequence of the diminished barometric pressure. This does not apply within the thorax, the deficit being more than compensated for by the increased respiratory effort. There are, of course, certain sequelæ following disease of these organs in the treatment of which benefit may rationally be expected from residence in high altitude, as, for instance, jaundice, whether the result of obstruction, or of catarrhal origin; but with such limitations it may be safely stated that, as in heart affections, it has no place in the therapeutics of diseases of these organs. Rheumatism, gout—indeed, lithiasis in any form—seem not to be affected one way or the other. Acute infectious diseases, as fevers, continued and malarial, diphtheria, scarlet fever, small-pox and measles, are undoubtedly modified; not only is the general systemic depression, as a rule, much less marked, but they run a shorter course, convalescence is more rapid, and the local lesions and sequelæ are less pronounced, and of less frequent occurrence. I think all observers are agreed upon this point. These effects are doubtless due to the fact that the virus of these diseases is, in its propagation outside of the human

body, attenuated by climatic conditions which it has to encounter: the dry, rarefied, aseptic, and highly diathermic condition of the atmosphere not being conducive to the luxuriant growth of low organic forms. In no one of the diseases mentioned is this marked mitigation of virulence more striking than in diphtheria (which just at this time is prevalent here) elsewhere so fatal and so fraught with distressing sequelæ; here it is a rare occurrence for the disease, if properly treated, to have a fatal termination; and the large majority of cases recover almost as speedily and with as little suffering as from an attack of ordinary tonsillitis. Diseases of the upper air passages, catarrhal affections, both naso-pharyngeal and laryngeal, are, as might be inferred, affected differently, the hypertrophic forms being as a rule benefited, while, in the atrophic forms, the dry catarrhs, the effect is to aggravate rather than to palliate.

Having thus briefly gone through the catalogue of extra-thoracic diseases commonly encountered, and with the few exceptions noted found altitude to have, putting the best face on it, only a negative influence,—

"May it please your highness to hear me speak his good now."

Bearing in mind the physiological effect of altitude, using the word in the broadest and most comprehensive sense, so as to cover all the attendant conditions before specified, we find its most general application in those forms of defective nutrition termed by Cohen "hypotrophy," a defect in the constructive or tissue-building powers of the organism, a lack of "potential energy," that power resident in living substance which enables it to transmute physical and chemical into vital processes, and to transform inanimate matter into the material basis of life. This deficiency is manifest in the lack of resistance that its subjects possess to deleterious influences from without; these it is whose respiratory tracts constitute the best culture medium, the most receptive soil for the germs of disease.

To enter exhaustively into this subject would occupy more space than the limits of this article contemplate; consequently it must suffice to say that the condition mentioned may be either congenital or acquired: in the former case there has not been transmitted to the embryo from its progenitors that equivalent of potential energy, which, in its future evolution and growth, is requisite for its perfect development. The acquired form results from privation, exhaustive diseases, excesses of all sorts, etc., and leaves its victims with such enfeeblement of function that the processes of tissue metamorphosis, both constructive and retrograde, are so impaired that both anabolism and katabolism are imperfectly performed, and the result is inability to resist depressing influences from without and an imperfect elaboration of the normal products of secretion and excretion. Like a lamp with a cracked chimney and a poorly trimmed wick it burns, but the light is dim, the flame is fitful, stirred by every passing breath of air; in an imperfect way it consumes the oil, but the chimney is smoky and the soot that gathers is evidence that the combustive process is as deficient as the light evolved is lacking in lustre.

These constitute the ideal subjects for altitude treatment. It is in these cases that the increased respiratory effort, the quickened circulation, the more abundant oxygenation of the blood, and the consequently more perfect performance of all the processes of nutrition, both constructive and retrograde, give new life; and endow with a power of resistance that places the individual on a level with his more fortunate brethren, and enables him to successfully cope with the host of deleterious influences existing in his environment and which constitute an ever-present menace to his well-being.

The classes of patients with *actually existing* disease-lesions (as contra-distinguished from the foregoing predisposing bodily conditions) to which the altitude treatment is applicable was adverted to in a former article (JOURNAL, page 949) and the views and conclusions of eminent authorities quoted; further mention of them is therefore omitted, as it would be a mere repetition.

WHAT BACTERIA DO.

The following extract from an article by Dr. Wm. B. Canfield, of Baltimore, is taken from the pages of *The Mother's Nursery Guide*, a monthly journal which should be known to our subscribers, since it contains many suggestive and instructive papers of value to mothers and so may be recommended to them by family physicians. It is extracted, of course, from one of the more scientific articles; most of the papers dealing with subjects of only domestic interest:

If it were not too startling a fact, it might be well to remember that in the mouth of each healthy person there are about twenty or more different kinds of bacteria always present. Many of these are useful in splitting up the food which is chewed, and they help it to be prepared for digestion; other bacteria protect the teeth, and prevent decay and the collection of tartar on the back of the teeth; again, other bacteria keep in a proper state the saliva which is of use in mastication and preparing the food for the stomach. There is no doubt that we have in parts of our digestive tract bacteria whose duty it is to assist the breaking up of the food, digestion and assimilation.

Outside of the body, bacteria are our friends; thus, when refuse animal matter is thrown out and undergoes what we call decomposition, it is the action of a large number of busy little bacteria that break up this matter and reduce it to its ultimate parts. Bacteria cause fermentation, and they are artificially cultivated to make beer. Light-giving bacteria cause phosphorescence on the surface of water.

Thus, we see that these bacteria make their presence known in a variety of ways, and are often of great use to us. To say that there are bacteria everywhere would be exaggerating the truth; but that they are very prevalent is not doubted by those who know, and they are particularly abundant in crowded communities, in cities and in enclosed places where many people congregate; this is especially true of hospitals. Some of these bacteria have an independent power of motion, but none of them have powers of locomotion, and hence they cannot go about and are not apt to float in the air unless attached to some microscopic piece of dust. Such bodies, too, have a tendency to settle on the ground, so that the air in a closed room is comparatively free from these impurities; but in a room where there is much motion there is always dust in the air, and there is always a chance that some bacteria may be attached to this dust.

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BALTIMORE, SEPTEMBER 24, 1892.

Editorial.

HOW THEY TREATED CHOLERA IN 1832.

We have in vain besought some of the medical men of our city whose practice began in the "thirties" to give us a sketch, in a conversational style, of the way they handled their cholera patients in our last great epidemic. In despair we have turned to that prince of lecturers, old Watson, whose book on Practice is one of our most valued treasures. And he does not fail us. What could be more simple, more graphic, more *honest* than his description of cholera as he saw it in England in 1832? For those of our readers who have not his lectures within reach we quote loosely a few passages:

"Cholera should (by the derivation of the word) indicate a disease, like cholera morbus, in which *bile* is discharged, but in fully developed Asiatic cholera the matters ejected from the stomach and bowels *contain no bile*. At first, perhaps, the patient would have a stool, thick or thin, so large as to seem to show that the bowels had been quite emptied. Yet soon afterwards a turbid whitish liquid would again and again pour from his bowels in streams; and be spouted from his mouth as if from a pump; not in general with much effort, but easily and abundantly. This had no fecal odor. There were some varieties in the evacuations, but those like rice-water with white flakes were the most common. If the physician left his patient for half an hour he found him *visibly thinner* on his return. The voice became husky and faint. So peculiar was its change that the sound was spoken of as the *vox cholerica*. Cramps seized the thigh and the calf muscles, making them rigid as wood. The pain of these cramps constituted the chief suffering of the patient; suppression of urine attended this stage of collapse. One man whom I treated passed not a drop of urine from Sunday morning till Wednesday afternoon. The *return* of bile to the stools and the secretion of urine were signs of convalescence. A singular phenomena was occasionally observed in the dead body. A quarter or half hour, or longer, after the respiration and other

signs of life ceased, slight tremulous twitchings of the muscles, with even distinct movements of the limbs, were seen.

The exciting cause (which he believes to be the contagion of a minute animal organism), to be effective, required a fit recipient. The susceptibiliy of being hurt by the poison in its ordinary dose and intensity varied much in different persons; and in the majority was very faint, or wanting. (We know now, 1892, that the comma bacillus is destroyed in the stomach if the gastric juice has its normal acidity.) Suppose that the itch insects could fly, or were capable of being wafted through the air—they would represent what is conceivable of the subtle exciting cause of cholera.

Poverty was found to predispose the body to receive the malady; but to *intemperance*, especially the habitual use of distilled spirits, more than any other *single* cause, was the proclivity to become ill with it to be ascribed.

Rarely prodromes were wanting. Much more commonly *diarrhœa preceded the full symptoms of cholera, and this I take to be the most important practical fact that was ascertained during its prevalence among us.* When the disease was once fairly formed, medicine had very little power over it, but in the preliminary diarrhœal stage it was easily manageable. Neglect of this diarrhœa, *or the employment of purgatives,* with the idea that there were irritating matters in the bowels, were alike *fatal mistakes.* Purgatives hastened the onset of dangerous symptoms. Arrest the diarrhœa as soon as possible by astringents, aromatics and opiates. In many places the cholera epidemic was apparently checked by the establishment of public free *diarrhœa dispensaries.*

A hundred different remedies were announced, most of them all but infallible. Bleeding, mustard emetics, hot-air baths, injection of salt solutions or simple water into the veins, brandy, opium, cajeput oil (which rose to I know not what price), and calomel, are on the list. Sometimes they may have done good; sometimes doubtless they did harm. I had not more than six *severe* cases in my charge. I congratulated myself that my mortality was not above the average mortality. Three died, *and three (I will not say were cured) recovered.* These three recovered under several half-drachm doses of calomel, the pulse rising somewhat and the patient seeming to rally after each dose. Yet I will not say it cured them.

Some patients in the epidemic died comatose, perhaps over-drugged by opium. Never, certainty, was the artillery of medicine more vigorously plied—never were her troops, regular and volunteer, more meritoriously active. To many patients no doubt this busy interference made all the difference between life and death. But, if the balance could be fairly struck and the exact truth ascertained, I question whether we would find that the aggregate of mortality from cholera (fully developed) in this country was any way disturbed by our craft."

Who could view disagreeable facts more judicially and with more humility than our author? How different from the blatant self-assurance of pleaders for special (alleged) remedies. It is to be hoped that the hypodermic syringe, the use of acid potions, injections of sterilized saline solutions, disinfection of discharges and isolation will turn the scale in favor of "our craft" in 1892.

THE CAUSE OF ENTERIC FEVER.

One of the great obstacles to medical progress lies in the tendency of observers to direct their attention to one possible source of disease to the exclusion of other possibilities. Of late, much interest has been taken in this country in the spread of enteric fever through the medium of milk and drinking-water. The possibility of its extension by vegetable foods has been little considered.

According to the communication from Dr. Anderson, published in another column of this issue, the possibility of the spread of the disease by means of upturned soil has not received any attention at all by other writers than himself.

If we had trained observers instead of untrained political dependents on our force of Sanitary Inspectors, our Health Force might easily tabulate, in the coming season, some valuable observations in regard to the connection between upturned street-beds and outbreaks of enteric or other fevers. We have already recorded the fact that the keeping open of a sewer excavation for months last winter was attended by at least one case of enteric fever (in a physician) in that street, and by other cases of diseases believed to be favored by miasms. Will not one or more of our subscribers give us information on these points for publication?

Medical Progress.

DR. BROUARDEL ON "SUBMERSION."

The readers of the *Lancet* will be interested by some remarks of Dr. Brouardel: —"In deaths from submersion three mechanisms may come into play. The fatal result may ensue suddenly, at the very instant of the plunge. Here instantaneous inhibition of the respiratory, and perhaps also of the cardiac, centres occurs, probably through reflex action exerted by the cold, the principal afferent nerves being the superior laryngeal. In such a case the individual expires without a drop of water having entered the trachea. In another class of cases death may not be due to reflex inhibition at all. The submerged one may be unable to rise to the surface, being entangled at the bottom of the river by boulders or weeds. Experiments on animals show that here nothing penetrates into the respiratory tree during the first minute, the glottidean sphincter being in a state of spasm. But this spasmodic state is soon succeeded by relaxation and water then enters freely. A dog weighing five kilogrammes has been known to absorb thus in one minute no less than 400 grammes of liquid. In both the foregoing classes of cases artificial respiration either by the Silvester or the Laborde methods, together with, in the latter instance, evacuation of the water inspired into the lungs, may suffice to save the individual. Unfortunately, the third and much more frequent mechanism by which fatal drowning may occur is much more dangerous in its effects, and the means at our disposal are too often inadequate to avert the consequences. Here, the drowning man, before he is finally engulphed, struggles and reappears once or twice at the surface. His efforts at respiration introduce into his lungs not only water largely mixed with air, but also the contents of the stomach expelled from that organ by the violent contractions of the diaphragm. In addition there enters into the circulatory system a quantity of water equal to the fourth or even the third of the volume of blood, a fact easily proved by examination of the blood with the hæmocytometer. Then, again, the presence of

water in the ultimate alveoli causes the prompt exfoliation of the pavement epithelium with which they are lined, a circumstance which damages their respiratory functions. We have thus three conditions which render the chances of recovery problematical—viz., the obliteration of the bronchial tree by water, the hydræmia, and the spoilt state of the alveoli."—Paris correspondence of *Lancet*.

REFLEX PAIN.

In a very suggestive and instructive article in the *Omaha Clinic*, for September, Dr. Allison, of the Omaha Medical College, reminds us that: Heart, lung and thoracic pains are reflected along the upper dorsal nerves to the arm. Disorders of the digestive organs cause reflex pains in the inter- and infra-scapula regions running along the lower dorsal nerves. The pain of renal colic is felt about the anterior spine of the ilium, in the genitals and lower dorsal regions through the spermatic plexus, and the inferior mesenteric and the posterior dorsal nerves.

The lumbar plexus supplying the leg above the knee, the lower abdomen and the external part of the hip, associates with the inferior mesenteric and spermatic plexuses of the sympathetic.

The transferred pain of the hip joint disease to the inner side of the knee belongs to this zone—the obturator nerve supplying the joint and skin about the knee. The lower visceral disturbances, including the sigmoid upper rectum and colon, are prone to be noticed in the hypogastric and umbilical regions on account of the origin of the superior and inferior mesenteric plexuses coming from the aortic and this plexus directly from the solar. We have, therefore, the symptoms of hernia, volvulus, and early appendicitis felt about the umbilicus. The sacral plexus supplying the leg, perineum, genitals, gluteal and anal regions, displays communications little less complex than are those found about the cranium.

Vesical calculi generally cause pain in the perineum, genitals, loins or in the heel,—the sacral supplying the base of the bladder sends a communicating filament to the sacral plexus, which allows a distribution over the pudic in the perineum and genitals or over the great sciatic in the heel. Uterine or ovarian irritation felt in the heel is due to a transfer in the sacral plexus or to congestion and pressure upon this plexus.

The frequent reflexes between the third portion of the rectum and the urethra or bladder can be attributed to the pudic or fourth sacral, and diligent research will throw light upon the most obscure cases. The upper rectum and sigmoid, however, are less sensitive, but have a more abundant sympathetic supply with symptoms correspondingly vague.

Careful investigation will, I am sure, account for the *nervous rectum* of Goodell, the *rectophobia* of Kelsey, and the *irritable rectum* of Mathews. (1) By locating an abraded surface with an exposed nerve trunk high up in the rectum, or (2) by revealing an accumulation—probably small—of fecal material in the sigmoid, or (3) a congested condition from constipation, attending which pathological conditions will be found, and the persistent vomiting, the disordered digestion, the irritable bladder or menstrual irregularities which seem to have no definite cause can be accounted for: and in this location it is the inferior hypogastric and inferior mesenteric plexuses, with their immediate communications and functional relations with pelvic organs and their direct supply from the solar plexus, that make this field so prolific of reflex disorders.

NEBRASKA TYPHOID.

In the *Omaha Clinic*, for September, Dr. Long, of Madison, gives an extensive paper on "The Continued Fever of Rural Nebraska," in which he says:

All the important attributes common to malaria fevers are wanting in this disease and quinine has no influence over the course of the disease, except as a tonic.

Well-developed cases of the disease have the following attributes common to typhoid fever: The gradual onset of the disease, the gradual and regular increase of temperature, the slight hacking cough, epistaxis, iliac tenderness, mild diarrhœa. After the first week, listlessness, delirium, rose-colored spots, tympanites, hæmorrhage, the dicrotic pulse, dry, glazed and fissured tongue and the decline of the fever by lysis.

One is forced to the conclusion that the continued fever of rural Nebraska is typhoid fever.

In a great majority, probably ninety per cent. of the cases, the fever runs a mild course; delirium is rare. Noticeable diarrhœa is present in perhaps less than two-thirds of the cases. Constipation may even exist; but purgatives always find a tender spot in passing through the intestinal tract; the characteristic eruption is very rare. Cases of the abortive form are frequently seen, where, any time from the seventh to the fourteenth days, the fever declines and the patient is convalescent.

It is not uncommon to see so-called walking cases in which the temperature does not exceed 102 degrees, the patient moping, sitting or lying around, but refusing to go to bed. These cases, as well as the abortive, frequently are seen in families where there are others sick with well-developed typhoid fever: hence the nature of the illness cannot reasonably be doubted. It is due to the fact that the typhoid fever of rural Nebraska is a mild and modified fever, which has given rise to the difference of opinion regarding its pathology, etiology and diagnosis.

What influence could operate to modify the course, severity and duration of typhoid fever in Nebraska?

It may be suggested that the high altitude, dry atmosphere, diffuseness of population, absence of timber, the comparative absence of decaying vegetation in moist places, and strong winds, combine to produce an atmosphere pure and rich in vitalizing ozone, tending to make the system stronger to resist the inroads and more capable of throwing off the morbid products of the disease.

The typhoid fever of rural Nebraska is a rare disease in wet seasons; it thrives in the dryest autumns, when the water level in the earth is lowest.

NEW FORMATION OF BONE.

In discussing an article on bone-grafting before the Allegheny County Medical Society, Dr. Duff (*Pittsburgh Medical Review*), said:

From what I have seen (I have not practised bone-grafting myself, but I have seen and read), I think there is a very bright future before us in bone-grafting, and yet we want to bear in mind, as Dr Thomas says, that bone has very great recuperative power. I had a young lady to come to my office one morning, who is not over twenty-one years of age. I have only seen her occasionally in the past few years. In the fall of 1876 she took scarlet fever. She suffered a relapse, and one abscess after another formed. I removed eighteen pieces of bone from her humerus and from the spinal processes. I cannot state the exact number. Two or three were removed from the femur. This condition ran for a long time, when it became evident that the tibia would have to be removed, and in the presence of Drs. Sterling, O'Connor and my father, I removed the shaft of the tibia, removing all the bone, which I still have in my possession at my office; all of the shaft of the bone, and, I thought at the time, all of the periosteum. I

advised amputation at that time, but we thought we would await results. Within six months after that there was apparently a complete bony formation in the midst of the tibia. It was very much thicker than the tibia originally, but it was solid. She is a twin, and the two sisters resemble each other very much. She walks by the side of her twin sister to-day, and it is with difficulty that you can tell the lame one. I have asked this lady two or three times to come before the society, but she is very modest, and I cannot prevail upon her. I shall be glad at some future time to show the bone which came from her. This case, with some others not so aggravated, leads me to believe the bone has a greater recuperative power than we generally attribute.

ONE OF THE SOURCES OF DANGER IN CHLOROFORM ANÆSTHESIA.

Writing in the *Omaha Clinic*, September, Dr. Mansfield says: I have taken chloroform myself to anæsthesia at least five or six times during the last eleven and one-half years, and have administered it, or had it done by my wife, not less than a thousand times in the period of a quarter of a century and almost exclusively in my private practice, covering cases trival in their import to such as adherent ovarian tumors, demanding for their removal several hours of time. The inhalation commenced, the vapor passes along the bronchial tubes to the air vesicles, and not only from these, but also through the smaller bronchi it penetrates and finds its way into the circulation, there to be absorbed, partly by the plasma, and to a greater extent by the blood corpuscles, whence it continues to every part of the organism. But how? By passing through the walls composing bronchi, bronchioli, air vesicles, arteries, veins and capillaries. Most of these contain a layer, (the middle one), of unstriped muscles (involuntary); and the central organ, the heart, is itself a hybrid between the celi-formed and fibre-shaped muscle tissue. The primary effect upon these, one that has been hitherto entirely overlooked, is that of relaxation—a paralytic action of the agent deprives the tissue of its tonus; it loses little by little, as the narcotism increases, its contractility, and a gradual dilation of the whole system of tubes ensues—of course the heart included; those less resistant yield first, the thinner-walled veins and right heart; an over-filling of them ensues, the patient is bled into his own blood-vessels, and a lower blood pressure is the outward token of this condition. It is at this stage of anæsthesia, when the involuntary muscle tissue struggles with great odds against the poison, that the greatest danger point is reached; and if the administrator does not fully realize that he must carefully train the muscle tissue to perform its work in spite of the powerful antagonist—in other words, teach it to become accustomed to its presence *gradually*, but *persistently*—some part of the system may give way—and this "*giving way*" will depend entirely on the accidental *weakest point* in the individual. If, as already pointed out, the lungs are impeded in their normal action by pleuritic adhesions, etc., an asphyxia, evolved by mechanical means, results—of course—caused primarily by the paralysis of the whole system of muscles included in the vast bronchial tree. If, on the other hand, lesions of the heart and its accessories exist, which greatly interfere with its proper function, the danger point must be placed in it, and a *mechanical syncope* will quickly and irredeemably terminate life. Bear in mind the fact that the more concentrated the administration and the more rapid the inhalation, the quicker will the latter accident supervene.

SOUTHERN WIT.

The way in which certain of our medical editors sail into each other at times is extremely refreshing to an onlooker, especially on a hot September day. Hoping

that the following may put some reader into a better condition to resist the cholera, we insert it from *Daniel's Texas Medical Journal* for September:

Dead Again.—Poor little dickey-bird Fisher, of the *Southern Journal of Homeopathy*, is, as an editor (?) dead again. Old readers of the *Journal* will remember how touchingly we related his early demise when as an editor of the little *Pellet* he failed, and gave up his little homeopathic ghost with a "tit willow" gasp. He died then of an attack of *Daniel's Texas Medical Journal*, and he is dead of a relapse of the same malady now. He throws up the sponge convinced at last that he could never make a success as an *editor*. "Was it weakness of intellect, birdie, I cried, or a very tough worm on your little inside?" Both, doubtless—the red-back journal which never lets up on homeopathy was worse than the tough worm, it was a Nessus shirt—and poor Fisher could not stand it. In the last issue of the *Southern Journal of Homeopathy* he chronicles his demise editorially, dying in orthodox theatrical style, taking four columns to expire in, after he is down:—like the villain in a blood and thunder play. The publishers are to be congratulated. The *Southern Journal of Homeopathy* is a pretty fair publication and has a wide field and ought to be made to pay: all that has been needed is an editor. Adieu, dickey-bird; peace to your little homeopathic ashes!

Correspondence.

Rockville, Md., September 15, 1892.

Editor Maryland Medical Journal:

Dear Sir:—In your issue of September 10th, you published an abstract from an article by Sir C. A. Cameron, President of the Irish Medical Association, taken from the *Lancet*, of June 11th, setting forth the theory that typhoid fever had its origin in the earth near the surface.

You not only published it, but *called attention* to it. Years ago in a letter to Mr. Henry C. Hallowell, President of the Board of Health for Montgomery Co., I expressed the belief that typhoid fever came from the ground and that it entered our bodies mainly through dust, and I was the *first* in *America* to promulgate that doctrine. I read the paper at the meeting of the Medical and Chirurgical Faculty of Maryland, held here last November, expressing the same views. The managers of our county papers were present and published extracts from several of the papers read at that meeting. The portion of my paper which I send you was clipped from the *Montgomery County Advocate*, of November 20th, 1891.

There has been but one typical case of typhoid fever this season, in Rockville, and there is some doubt about that being contracted here. I think we owe immunity to the facts that our paved streets have been scraped after every rain and the dirt carted away, and that our trees have grown large enough to arrest the dust before it reaches the windows of our sleeping-apartments.

Yours truly,

Edward Anderson, M. D.

The following are extracts from the newspaper clipping enclosed by Dr. Anderson:

Each one of us, physicians of this town, have not only felt the effects of this fever in our own families but in our own persons. Happily we are all here to-day to discuss it. Sir Thomas Watson says decomposing animal or vegetable matter is incapable of producing fever of any kind, and he is right. The late Dr. G. B. Wood, of Philadelphia, says the predisposition to typhoid fever is as strongly in-

herited as that to tubercular consumption, and he is right. I say the fever from which we suffer is produced solely by germs arising from our clay soil after it has been thoroughly dried by the sun's rays when the temperature is high, and I hope to prove that I am right. The only writer, as far as I know, who agrees with me is Professer Welch, of Johns Hopkins University. Each plant has a butterfly peculiar to itself, so also has each soil a fever germ peculiar to itself. Ours is a stiff clay soil which throws off the typhoid germ. Sandy soils throw off the germ of intermittent fever, a disease much less dangerous to life than typhoid, but much more difficult to eradicate. I do not expect to make you think as I do upon this subject, but if I can induce you to investigate this matter for yourselves I will feel amply repaid.

The idea has so long possessed the medical mind that typhoid fever is never taken into the system except through drinking water that it is hard to remove it, —the idea that the germs had to be cornered, as it were, before they could affect us, by being driven into wells and water courses.

I do not deny that this disease might be taken into our bodies in the water we drink, for germs might be washed into wells and other receptacles of drinking water. One reason for believing that the disease is due to the drying of earth near our dwellings is that we never contract it until a portion of that earth has been converted into dust; another is that although they all drink the same water only those who are exposed to the dust contract the disease. I have never seen a case of typhoid fever in the county unless excavations had been made, lands cultivated or earth exposed near a dwelling in some other way; if these things are done, a dry season is apt to affect every susceptible inmate. This fever prevails most in mountainous regions, and as ours is a rolling country with a stiff clay soil we have our share. Many persons attribute the fever in Rockville to imperfect drainage, but the more perfect the drainage the more fever we have.

Our town is built for the most part on three streets running east and west; the central or main street upon which most of the houses are built is well drained, paved with broken flint stone overlaid by a few inches of earth which is thoroughly dried by a few hours of sunshine; the other two streets are unpaved; the northern one, commonly called the back lane, is the receptacle of a great part of the sewage and filth of the town, yet it is free from fever because it is never thoroughly dry. Fever is confined almost exclusively to the main street, and I believe nearly every death from this cause has been upon it. Nature is constantly striving to shield us from harm by throwing out her protecting arms in the shape of tree branches and by covering the earth with sod, and if we do but allow her full sway we are safe. Where the earth cannot be protected from the sun's rays by trees, or grass cannot be made to grow, fever germs should be kept down by pavements and no earth should be allowed upon it.

At the afternoon session the discussion was concluded by Dr. Welch, who said, that while Dr. Anderson's theory was held by a most eminent school of hygiene at Munich, this was the first time it was advanced in this country, whereas in England the impure water theory was held, but he did not see any reason why this soil theory might not be correct; he further stated that his experience had convinced him that typhoid exists in a number of cases where the symptoms did not tally with those laid down in the text-books, and physicians could not have too prominently in their minds that typhoid lurked in many disguises.

Prof. J. H. Thompson, of Kansas City, reports a case of hæmorrhage after enucleation of an eye—probably the first on record, though likely to occur in any case of hæmophila.—*Ex.*

Recommendations of Therapeutic Agents.

OVER-PRESSURE IN CHILDREN CAUSING BRAIN MISCHIEF.

The following cases show the inadvisability of attempting to force children forward in schools without sufficiently considering their different individual capacity for learning.

It is, I am afraid, much too common a cause of children's ailments nowadays and has not been quite enough considered, I think, by parents and teachers. In the ordinary Board School, as at present constituted, every child in each standard must be pushed on *pari passu*, with all the others, so as to get all, if possible, passed at the examination next ensuing, into the standard above. In the first case here noted, the fault, *fons et origo mali*, was with the parents in sending such a young child to a school at all, but as both parents were factory workers, and there was only a slightly older boy besides, the child went to school with him.

Both cases were very similar in the onset, but the first was the most severe, and in both I thought at first the illness was enteric fever, the more so as being next door neighbors and residing on the banks of the river, which is very foul and much polluted, and on Sundays, when the water is low, great banks of festering abominations are exposed.

Case 1. Alf. C., a sharp and more than usually intelligent little boy, of only four years and eight months, was seized on April 3rd, at breakfast time, with sickness and pain in the head. He had been attending school for six months, and naturally quick, as I have said, he had been encouraged to learn, and had already reached the final class in the infant department, and would have been put into the general school but for his age, which forbade it.

When I saw him at 11 A. M., he was in bed, slightly flushed, head very hot, and temperature 99.2°. Tongue rather foul. Complains of pain in the head, and avoids light. No further vomiting since breakfast. Gave him a mixture of potass. citrat. and tinct. aconiti and calomel, gr. j., with sugar.

April 4th. Passed a bad night, rambling and talking about school. Tongue rather cleaner. Temperature 99.4°. Milk diet. To continue mixture. Night temperature same as morning. Added k. br. gr. ij., aa dose, to medicine.

5th. Night passed much the same as last. Lies very quiet and still, but easily roused, and then quite conscious. Temperature 100.2°. Thirsty. Tongue furred, but moist. No pain in abdomen. Stool natural. Ordered antipyrin, grs. v., every three hours. Temperature at night, 100°. Been delirious all afternoon. Ordered ice-bladder to head.

6th. Rather better this morning. No diarrhœa. No spots on abdomen. Head, however, very hot, mother having taken off ice-bag at 4 A. M., as child slept. To be replaced. To have 5 mins. bromidia (Battle) every two hours. Temperature, 100.2°; night temperature same.

7th. Much better. Fairly good night. Slept four hours; twelve midnight to four A. M. Playing with toys on bed when I saw him. Temperature, 99.2°. Tongue cleaner. To continue bromidia mixture.

8th. Not quite so well. Ice-bag again neglected, to my vexation. To be continued, as also mixture.

9th. Much better. Sitting up playing. Temperature 99°. Ice-bag discontinued. Same mixture.

10th. Improving fast. Not much appetite. Quin., gr. ½, t. d. s.

11th. Up and dressed. Still improving. No headache or pain. Temperature

normal. With the exception of a slight cough all went on well until the 14th, when I discontinued visiting.

The good effect of the ice and bromidia was very quickly apparent in this case, as also in the next.

Case 2. Jno. B., a strong, sturdy, rough lad of just over seven years of age, was a contrast to A. C., in that he was anything but fond of lessons, and rather dull in all subjects except drawing, in which he excelled.

He had failed last year in the examination, and in consequence his teacher had been urgent as to the necessity of his passing this time, and had been, perhaps, rather too sharp on the lad.

Just a fortnight before the examination, on April 21st, he was seized, also at breakfast time, with vomiting and pain in the head.

When I saw him in the forenoon he was lying on a bed-chair, very drowsy, and resenting being roused. Had vomited every few minutes since breakfast, at which he had only drank a cupful of coffee. Head very hot. Pupils contracted; buries his face in the pillow. Temperature, 100°.

Ordered cold water cloths to head until ice-bladder could be gotten, and a potass. citrat. mixture.

April 22nd. Sickness relieved. No delirium, but wanders when roused, and talks of his play. Ice to the head. Bromidia, m. v., every two hours. Night much the same. Temperature, 100°.

23rd. Much better. More easily roused, and sensible, though when left to himself lies quiet for hours. Temperature 99°. To continue bromidia and ice.

24th. Better. Sitting up in bed with his drawing-book. No dulness or drowsiness. Complains of no pain at all. Appetite is not good. Quin., gr. ½, t. d. s.

25th. Appetite improved. No bad symptoms. Temperature normal. Playing about the bed-room.

26th. Ceased visiting. Boy going on well.

It seems curious to me that two lads of such opposite temperaments should be so similarly attacked. One sharp and intelligent, though very young and not compelled to learn; the other older and duller, probably harassed by his teacher; and yet both develop almost the same symptoms. I may say that the younger child, a fortnight after I ceased seeing him, had a regular hysterical fit because his mother would not allow him to go to school with his brother, and was in a state of collapse, cold and pale, for two or three hours after.

The rapid improvement under the ice and bromidia treatment was very gratifying, and I have found bromidia especially useful in such cases, and a very reliable hypnotic whenever I have required to prescribe such a medicine.—J. A. Diggle, L. S. A., London, in the *Hospital Gazette*.

Medical Items.

The commercial unit of electricity, formerly known as the Board of Trade unit, is hereafter to be called the kelvin.

It is claimed by the *Pharmaceutical Record* that the Keely "cure" contains hydrochlorate of apomorphia.

It is said that a few drops of oil of cloves on the pillow will drive away the Indian mosquito. As far as we know it has not yet been tried on our "Eastern Shore" variety.

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CONTENTS

ORIGINAL ARTICLES.

What Shall be Done with the Imbecile? By S. J. Fort, M. D., Ellicott City, Md. . . 1057

A Plea for the Correct Pronunciation of Medical Terms By Wm. Dulany Thomas, M. D., and Eugene L. Crutchfield, M. D., F. S. Sc., Lond. 1064

EDITORIAL.

Difficulties of Medical Pronunciation. . . 1067

Our Weekly Chronicle. 1068

REVIEWS, BOOKS AND PAMPHLETS. . . . 1069

MEDICAL PROGRESS.

Treatment of Sea-Sickness.—Death Hastened by an Emetic.—The Ramblings of Cholera.—The Difficulty in Diagnosis of Thoracic Aneurysm.—Midwifery in India.—Antimony and Coto in Diarrhœa. 1071

MEDICAL ITEMS. 1075

Original Articles.

WHAT SHALL BE DONE WITH THE IMBECILE?*

BY SAMUEL J. FORT, M. D., OF ELLICOTT CITY, MD.

It is with some diffidence that I venture to offer this representative body of medical men a few thoughts grouped under the subject, "What shall be done with the imbecile?" My apology for the infliction must rest upon the plea that Virginia has provided for her insane population with a magnificent generosity second to no other State in the Union, yet with over 3,000 idiots among her population, has made, as yet, no provision for these neglected creatures. It rests largely with the medical profession to further any public movement which looks towards the arrest and prevention of disease as well as piloting the patient through his illness. We are entering an era of preventive medicine and while we may not see idiocy stamped out of our population in this generation, we are the pioneers of a movement which if properly carried out cannot help but establish rules for the guidance of those who are to come after us, in performing the radical surgery which shall extirpate the blight.

With this, then, as my apology, and with the hope that some practical knowledge of the idiot, his needs and demands may be extracted from what follows, I beg your sufferance for a few minutes in his behalf.

*Read before the Medical Society of Virginia, meeting at Alleghany Springs, September 14th, 15th and 16th, 1892.

Time and space will not permit me to enter too deeply into the etiology of idiocy, but for the better presentation of the subject permit me to outline a history of the work of caring for them as developed in America during the past thirty years. It is certain that the peculiar form of idiocy known as cretinism was acknowledged by the ancient writers; among others, Vitruvius mentions them and their goitres, describing them as monstrosities, and regarding them, as did most of the writers up to the beginning of this century, as the results of supernatural influences.

No less a personage than Martin Luther claimed that idiots were possessed of devils, urging in one instance that particularly hideous creatures should be drowned in the Moldau, and roundly denouncing as "blockheads" those who attempted to alleviate their condition. Fortunately this ardent reformer was almost alone in his pessimistic views, and it is a matter of history that as early as the 16th century the monk Bartholomew collected about him a few poor cretins and endeavored to train them to assist him in the cloister-gardens and halls. The mediæval literature of Germany and Scandinavia abounds with stories of changelings, or the offspring of hobgoblins left by these supposed beings in the place of the babe which they snatched from the cradle and carried to their subterranean abode. Other nations, the Irish for instance, held the innocents in reverential awe as marked by God's finger; the Hindoos recognized the condition as one that needed the utmost care and attention lest some overt act of the weak one should cause a loss of caste. Outside of the Koran, which expressly enjoins that if a man has a feeble-minded brother he shall not give him his share of his inheritance, but clothe him and feed him and speak kindly to him, there was not a page of scientific, philanthropic or religious literature devoted to idiocy when this century dawned, unless it was some comments upon endemic cretinisms as existing in certain valleys of Switzerland and Savoy. Outside of a few religious establishments in Switzerland that sheltered a meagre number of cretins, no effort had been made to care for such unfortunates: and until Ward's experimental training of the so-called "Savage of Aveyron," nothing had been done to ameliorate the condition, either mental or physical, of the ill-fated imbecile. It remained for the elder Seguin, a pupil of Idards, to develop a system of training which remains to-day the great monument of his skill and acumen and the veda of those educators whose lifework has to deal with the idiot.

Closely associated with Seguin was Guggenbühl, the young Swiss physician whose institution in the Abendberg, near Interlaken, became a sort of Mecca for those interested in the idiot; and from these nuclei a sympathetic wave of interest spread across the ocean to America, where, in 1848, Dr. H. B. Wilbur opened a private school at Bane, Massachusetts, and, later in the same year, the State institution was opened in South Boston. New York started her great work with these unfortunates in 1851, Pennsylvania in 1853, Ohio in 1857, Connecticut in 1858, Kentucky in 1860, Illinois in 1865, Iowa in 1876, Minnesota and Indiana in 1879, Kansas in 1881, California in 1884, New Jersey in 1888: Maryland's State Institution opened in 1888 also, though the work was inaugurated

in that State in 1886. Besides these fifteen State institutions, there are several private institutions caring for a certain number of cases from the more wealthy families, the entire number under care and training approaching 5,000.

The census of 1890 puts the total number of idiots in the United States at 95,571, an increase of 18,676 since the last census. In the State of Virginia, there are 3,090 idiots and as there is no provision whatever made in this State for their care, except as it may be their incarceration in almshouses or asylums for the insane, the harvest is here ready for the reaper. A patient study of the criminal records of the State would no doubt show the advantage of a proper legislation for their care in a decreased number of jail habitués and a corresponding decrease in costs which the State has to pay. There is no method by which the misery and injury done to the children by associating with their defective brothers and sisters, or the saving of wear and tear upon the family, to say nothing of the pecuniary economy of massing them in one common family under one head and management, can be better illustrated than by the glorious history of our State institutions for the imbecile. The sum total of insane in the United States is only slightly in excess of the total of idiots, and the query arises, Why should our Legislature halt in doing their duty by these equally unfortunate members of the body-politic?

The insane, the deaf, the dumb and the blind, have received special care for several generations, yet here is a class of helpless ones, handicapped by defect, crippled by infirmities, having seeing eyes that see not, hearing ears that hear not, innocent sufferers for sins they did not commit, sitting in the shadow of a misery greater than that of other defectives: these most afflicted of the afflicted have found until recently all doors closed against them save those of the jail and the poor-house.

Seguin attempted to classify the phenomena of idiocy upon the assumption that its mental and moral features were dependent upon conditions of the nervous system and he proposed to inquire into and classify upon the underlying facts, viz., whether that portion of the nervous system constituting the channel of communication between the world of relation and the individual was affected, or that deeper or more central portion whose function is to receive, to feel, to consider, to act upon the stimuli, the perceptions communicated from without: he thus makes two essential forms of idiocy.

1st, The chronic affection of the whole or a part of the central nervous masses which he characterizes as *profound idiocy*.

2nd, A partial or total affection of the nervous apparatus which ramifies through the tissues and presides over the life of relation, the result of which is *superficial idiocy*.

3rd, "Backward children" (*l'enfant arriéré*); this latter class seem to illustrate a condition of retarded mental development in early childhood which may be said briefly to result from a mere functional torpidity of the nervous system. It may be said here that while this class of backward children is recognized today, I am not at all certain that many are to be found whose mental condition

is that of *torpidity*; the arrest of development is either pre- or post-natal and the result is an actual and more or less absolute deficiency. This would seem borne out by Seguin's actual definition of idiocy, which he gives as follows:

"Idiocy is a specific infirmity of the cranio-spinal axis, produced by deficiency of nutrition in utero and in neo-nati."

Wilbur, in signifying his belief in the property of Seguin's classification, points out two forms of physical degeneracy, one symptom of which is more or less impairment of the mental faculties: cretinism, and that modified and more common form of the same trouble called the Mongolian or Kalmuck type of idiocy.

Gresinger defines idiocy as "a condition in which a state of mental weakness has existed from birth or early infancy, in which the *physical development* has been thereby impeded or prevented." "Individuals in these circumstances," he says, "remain to a greater or less extent below the average in intelligence, nor can they attain to the degree of education and instruction corresponding to their age and social condition."

He then divides idiots into two general classes:

1st, The more severe cases of intellectual nullity.

2nd, The less severe cases of simple mental weakness.

Ireland proposes a classification based upon pathological conditions, making ten divisions:

1st, Genetous idiocy. 2nd, Microcephalic idiocy. 3rd, Eclampsic idiocy. 4th, Epileptic idiocy. 5th, Hydrocephalic idiocy. 6th, Paralytic idiocy. 7th, Cretinism. 8th, Traumatic idiocy. 9th, Inflammatory idiocy. 10th, idiocy by deprivation.

Kerlin† has suggested four general groups to cover the chief varieties or grades, as follows:

1st, Idiocy; (*a*) apathetic, (*b*) excitable. 2nd, Idio-imbeciles. 3rd, Imbeciles; (*a*) lower grade, (*b*) middle grade, (*c*) high grade. 4th, Juvenile insanity.

I should like to have the time to go deeper into this part of my subject to draw you pictures of one or the other or all these grades or classifications, or, better yet, display before you the children themselves; let me suggest to you that a visit to an institution is at once the quickest and best and most entertaining manner of knowing what the imbecile really is.

"We might," says Kerlin, "consider helpless idiocy in its relation to organized society from two points.

"1st, That of the preservation of society itself from a baneful, hindering or disturbing element generated within itself and too often from avoidable causes.

"2nd, The right inherently existing in a defective and irresponsible member of society to protection by that body in exact ratio to his necessities."

Assuming these propositions to be true, and I think no one will deny either, we come to consider how best may the idiotic be cared for and such as are capable rendered capable of self-support, or, at least, able to earn a portion of their board and clothing.

†Report Standing Committe to 11th National Conference of Charities and Reforms, 1884.

The treatment of the idiot and the task of developing to the utmost such abilities as are latent in him is not confined to the therapeutist: pedagogic science must be invoked as well as the art of the physician; the defective one is a pupil as well as patient and pedagogic-therapy may yet attain the rank of a separate and distinct branch of medical training. It is not an uncommon error to assume that the idiot can be cured; in other words, that man can make normal what nature has made abnormal; it is perhaps a no less common assumption even with the present knowledge of what has been done with defective children, that nothing can be done for him, save to make him comfortable and keep him out of harm. Both assumptions are incorrect and in a certain sense do harm. Idiocy is not a disease; on the other hand, insanity is a disease; it has been said that the insane man is like one who has been rich and lost his wealth, while the idiot is like one born in poverty; idiocy is a defect, a deficiency; and while a disease may be cured, human instrumentality can never remodel nature's incomplete products and constructive failures; it can only do the best possible with the material given.

Now, having given some idea of what constitutes idiocy, what shall be done with the idiots?

We can safely assume at the outset that the day of speculation in regard to them is gone; the American institution has passed the stage of experiment. A half century of experience speaks in no hesitating voice of the only successful solution of the problem.

The institution furnishes a little world, a microcosm with its curriculum of duties and pleasures. Herein the idiot finds company; his isolation ceases; he is no more hidden away upon the approach of visitors; he is placed in school with other children, among whom he finds congenial playmates; he is placed under the guidance of a teacher who knows how to waken all his slumbering faculties and at the same time control his wayward disposition with a firm and dispassionate discipline.

It seems almost incredible that any thinking person or community cannot or will not appreciate the very evident fact that the distribution of idiots and feeble-minded persons, of whatever age, in any settled community, is not only detrimental to the individuals themselves, but subversive of the best interests of the family, and the neighborhood. The hundreds of so-called senseless human beings, constituting the defective population of the United States, who are utterly dependent upon others, and are irresponsible in the eye of the law, make, after all, the lowest stratum of the social scale. Next above them stand the helpless creatures supposed to know right from wrong, from whom are drafted nearly all the inmates of our jails; from whom are recruited the great army of tramps spread over the land, from whom are transplanted the members of another sorry phalanx of misery,—the abandoned prostitutes of large cities, and from whom, it may be said, perhaps, is drawn the host of alcoholic inebriates more numerous than all the insane, idiotic, blind and deaf, reinforcing the ranks of pauperism by other legions, and sowing a birthright of misery into the children of the third and fourth generations. Does not the sight of this huge army of defective depend-

ents suggest at once some means of prevention lest the last stage become worse than the first? Is not this plea powerful enough to prove the fulcrum upon which an Archimedian lever of right shall move the world of public opinion? Does it need more to convince that sequestration of such defectives is the only safe plan? Shall I tell you of the home over which the shadow of the affliction of an idiotic child is never absent? Of the worn and weary mother, whose entire time and attention is absorbed by the weak one, yet who *must* do her wifely duty by her husband, her motherly duties by her other children, and have hanging over her head the sword of Damocles, in the thought that yet other children may come who shall show traces of the fatal blight? Who can tell what the idiot himself suffers, not alone from internal disturbances, but from its ability, dull and distorted tho' it be, to see itself as others see it?

Under ordinary circumstances home environments are the most unpropitious for the welfare of the feeble-minded child: he is the skeleton in the closet; he is put aside from social gatherings lest he mar the harmony; for the same reason he is debarred from the privilege of the church and the Sunday-school; normal children shrink from him or taunt him with his condition and as an inevitable consequence the confinement and isolation aggravates instead of ameliorating his condition. It is asserted that any or all results obtained in the institution might be obtained at home. Theory and experience are here hand in hand, both proving that home talent is but rarely capable of producing the effects of the institution, and that, provided that the mother was competent, time nor opportunity would serve to enable her to work properly with a defective child, without doing injustice to the rest of the family; and even though other things were equal, the ability to teach and train children of deficient intellect is learned only by long experience and study. The epileptic idiot has been up to a very recent date most decidedly neglected. It would be too rash perhaps to say that no epileptic can be cured outside of an institution, but I do dot hesitate to assert that we have in the institution under the care of a skilful physician the ideal environment of the idiot afflicted with epilepsy. Aside from any utilitarian idea of preventing the disease by isolating the sexes, which is by no means a bad argument, I am convinced that a treatment in which diet and exercise, strictly enforced and carried out upon physiological and therapeutic lines, which can only be done where the authority of the medical man is supreme, is the treatment of all others the best, and if this fact was only more thoroughly appreciated by the practitioners at large, the younger epileptics would be reached at an age before the "spasm habit" has become too firmly impressed upon the muscular system, and if no better result is obtained than to diminish the spasms in number and force, that surely is worth striving for, and only rarely do we find a case in which no good result is apparent; under appropriate treatment too, the poor victim of this most dreadful disease is able to retain the remnant of mental power he was given at birth, or the shattered remains dulled and warped by the violent nerve explosions. It is not necessary to enlarge further upon the theory that institutions for idiots

are necessities. The right of the individual idiot to such moral, mental, and physical training as his capacity will permit is just as inalienable as that of his brother whose mental development is closer to the normal. In conclusion we may sum up the reasons why idiots should be sequestrated in special institutions as follows:

1st, The incubus of idiocy is removed from the home which it blights.

2nd, Idiocy is prevented from begetting idiocy.

3rd, Complications of the affliction are best alleviated through proper dietetic and medical supervision, and the less afflicted prevented from degenerating into profound idiocy.

4th, The industrious abilities possessed by a large percentage, which are useless elsewhere, are here available.

5th, The less afflicted are trained to care for the very dependent, under proper surveillance.

6th, They are saved from evil and temptation which they are unable to resist, when thus placed in a miniature world, *sans* its temptations.

Finally, the future of this work contemplates far more than the gathering together into training schools of a few hundred imperfect children. The correlation of idiocy, insanity, pauperism and crime will be understood as it is not now. There will be fewer alms-houses, but more work-houses. Jails, criminal courts and grog-shops will correspondingly decrease, and here and there scattered over the country may be villages of the simple, made up of the warped, twisted and incorrigible, happily contributing to their own and the support of the more lowly —cities of refuge in truth, havens in which all shall live contentedly because no longer misunderstood or taxed with exactions beyond their moral or mental capacity. "They shall go out no more, and they shall neither marry nor be given in marriage in those havens dedicated to incompetency."

In answer to the question "Is mountain or seaside best for baby in summer?" the editor of *The Mother's Nursery Guide* (formerly *Babyhood*) writes:

The question has no "yes or no" answer. Babies generally do well in any place which is healthy, not too hot, and where good food is to be had. The nursing baby should go where its mother thrives best. The weaned baby we usually send to cool hilly places, because, as a rule, the milk supply is better in such grazing districts than by the seaside, but exceptions exist of course. Avoid malarial places, avoid damp places, and, as a rule, avoid river bottoms if you have any choice. The point whether the mountain or the sea air—as such and aside from the points already raised—will best agree, is very hard to determine. The family practitioner who knows the family peculiarities can guess at the answer; but otherwise it often requires several years of experiment to determine which really agrees better with a growing child. Excitable children may thrive beside the sea because of the drowsy effect it often has upon them; on the other hand, its prevalent winds may excite.

Dr. E. E. Jones, of Arlington, has been appointed secretary to the local Board of Health of Baltimore county.

A PLEA FOR THE CORRECT PRONUNCIATION OF MEDICAL TERMS.

BY WM. DULANY THOMAS, M. D.,
AND
EUGENE L. CRUTCHFIELD, M. D., F. S. SC., LOND.

The amount of false pronunciation noticeable in the speech of medical men is a matter of which very few are aware until their attention is called to it. We refer here not to errors made in the use of their mother tongue, though the number of these is also truly appalling, for it is a well-known fact that physicians as a class are more deficient in general education than the members of any other profession. We desire, however, to call attention to some of the mistakes so common in the use of technical terms. This is a subject little dwelt upon. In fact, we do not remember having ever heard it alluded to from the lecturer's desk, nor have we ever seen an article in any medical journal in which this topic was discussed.

Of the importance of the question there can be no doubt. It is as necessary for a professional man to pronounce correctly the technical terms incident to his calling as it is for an educated person to observe the rules of orthoepy when speaking his native language.

We propose to mention, first, a group of words having a common ending generally mispronounced, and then to give a number of terms not admitting of classification, the pronunciation of which is also frequently at fault.

Groups: Words ending in *alis*, as digitalis, frontalis, pyramidalis, etc. In these the sound of *a* is long, as in the word day; not short, as in alley.

Words ending in *ata* and *atus*, as oblongata, innominata, meatus, hiatus, serratus, etc. Here also the sound of *a* is long (as *a* in gay).

Words ending in *cele* (Greek *ke-le*, a tumor), as hydrocele, bronchocele, mucocele. In these the termination should be divided into two syllables, so that the pronunciation of these words is, hy-dro-*ce*-le, bron-cho-*ce*-le, mu-co-*ce*-le. We are aware of the fact that Webster does not give this pronunciation, but it is that advocated by Dunglison, and it is certainly borne out by the etymology of these terms.

Words ending in *ery*, as dysentery, mesentery, psorentery. In these only the pre-antepenultimate syllable should be accented. Therefore, the pronunciation of these words is *dys*-entery, *mes*-entery, *pso*-rentery (not dysen-*ter*-y, mesen-*ter*-y, psoren-*ter*-y, as we so often hear).

Words ending in *itis*. In these, the sound of the first *i* of the termination is long (like *i* in kite). Consequently we should say bron-*chi*-tis, i-*ri*-tis, gingi-*vi*-tis; and not bron-*chee*-tis, i-*ree*-tis and gingi-*vee*-tis.

Words not admitting of classification (the accented syllable is in *italics*): ab-*do*-men (not *ab*-domen), *o* is long as in *note;* accele-*ra*-tor u-*ri*-næ, ac-u-*punct*-ure (Dunglison erroneously says "ay-cu-*punct*-ure"), ad-*ju*-vant (Webster) or *ad*-juvant (Dunglison), al-*bi*-no, albu-*gin*-ea, al-*lop*-athy, an-*æm*-ic (although Webster, ignoring the derivation of the word, makes it an-*em*-ic), an-*ti*-cus, *a*-nus (not *an*-

us), *a*-pis mel-*lif*-ica, appa-*ra*-tus, *as*-arum, asthe-*ni*-a (not as-*thee*-nia), *bro*-mide (pronounced *bro*-mid, *o* is long); *bro*-midum (pronounced *bro*-mid-um), ca-*da*-ver (*da* as in day), *can*-tharis, car-*bo*-nas, *ca*-se-ine or *ca*-se-in (not *cas*-e-ine nor *cas*-e-in), cer-*vi*-cis (not *cer*-vicis), *cer*-ebrum and *cer*-ebral (not ce-*re*-brum and ce-*re*-bral), *cer*-ebro *spi*-nal, ci-*ca*-trix (plural cic-a-*tri*-ces), cinni-*cif*-uga, *cat*-echu (pronounced *kat*-eshoo), *ci*-tras or *cit*-ras; *ci*-trate or *cit*-rate, *ci*-tric or *cit*-ric, *ci*-trus or *cit*-rus, chim-*aph*-ila (pronounced kim-*aph*-ila), co-*ro*-na, *chol*-ic (not *cho*-lic), *chin*-inum (pronounced *kin*-inum), *col*-chicum (pronounced *kol*-ki-kum), conjunc-*ti*-va, co-*ni*-um, cru-*re*-us, de-*tri*-tus, duo-*de*-num, *ec*-zema (not ec-*ze*-ma,) empy-*e*-ma, *en*-ema (plural en-*em* ata), ep-*u*-lis, epizo-*ot*-ic (not epi-*zoot*-ic), eu-*sta*-chian (pronounced yu-*sta*-kean) *ex*-crement, *ex*-cretory or ex-*cre*-tory, *far*-adic (not fa-*ra*-dic) fa-*ri*-na, *feb*-rifuge (*feb* as in *February*,) febrile (pronounced either *fee*-bril or *feb*-ril), fo-*ra*-men (plural fo-*ra*-mina) *ra* like *ray*; *gal*-banum, *gle*-noid, *glo*-no-in, glu-*taeus* (not *glu*-teus), gly-*coch*-olic, gra-*phi*-tes, guaiacum (pronounced *gwa*-ya-cum), hel-*leb*-orus, hydran-*ge*-a or hy-*dran*-gea, hy-*per*-trophy, hyper-*pla*-sia, hyo-*scy*-amus and hyo-*scy*-amine, il-*i*-acus and il-*i*-aca (*i* long), i-*o*-didum (not io-*di*-dum), i-*od*-oform (Webster) or *i*-odoform (Dunglison), ja-*la*-pa, *jug*-ular (Webster, ignoring its derivation from Latin *jug*-u-lum, says, *ju*-gular), *kre*-atinine (Dunglison) or kre-*at*-inine (Webster), le-*va*-tor, lichen pronounced *li*-ken or *litch*-en (as a medical word Smart gives *li*-ken, as a botanical term *litch*-en; Dunglison pronounces it *li*-ken); liquor (pronounced *lik*-ur), *mas*-seter (Webster) or mas-*se*-ter (Dunglison), mal-*le*-olus, matico (pronounced ma-*tee*-co), media-*sti*-num, mem-*bra*-na, met-*as*-tasis and meta-*stat*-ic, *mol*-ecule, *na*-res (genitive, *na*-rium), *na*-sus, neu-*rog*-lia, o-*rig*-anum, os (bone), short *o*, as in os innomi-*na*-tum, os (mouth), long *o*, as in os *u*-teri, *par*-esis, pharmaco-*pœ*-ia (pronounced pharmaco-*pee*-ya), phthisis (pronounced *thigh*-sis), phthisical (pronounced *tiz*-ical), phar-*yn*-geal or pharyn-*ge*-al, *plat*-ina or pla-*ti* (tee)na, so pla-*ti*-num or pla-*ti*-num, *pleth*-ora (Webster), Dunglison gives ple-*tho*-ra, in accordance with Walker's rule, that words imported *whole* from Greek or Latin should keep their original accents: ple-*tho*-ric or *pleth*-oric, *pre*-puce, pos-*ti*-cus, pru-*ri*-tus, *qui*-nia (Dunglison), quin-i-a (*kwin*-ia), quin-ina (*kwin*-ina) *qui*-nine or qui-*nine* (Webster); ranula (pronounced *ray*-nula), re-*si*-na, ro-*se*-ola, ru-*be*-ola, sacral and sacrum (pronounced *say*-cral, and *say*-crum), sa-*git*-tal (Dunglison) or *sag*-ittal (Webster) *g* is like *j*: sa-*ti*-va, schindylesis (Greek word pronounced skin-*dye*-lesis), se-*ro*-tina (*o* long), *squa*-mous (pronounced *squay*-mus) *syr*-inge, *syr*-up (*y* pronounced like *i* in sit,) sy-*ru*-pus, tabes (pronounced *tay*-beez), ta-*ran*-tula or ta-*ren*-tula, tau-*roch*-olic, tin-*ni*-tus (*i* of *ni* long), trachea, (preferable pronunciation tray-*chee*-a; allowable, *tray*-che-a; common, but wrong, *trak*-ee-a), troche (pronounced *tro*-kee, *o* long), *tym*-panum, umbi-*li*-cus (*i* in *li* long), vaginal (pronounced *vaj*-inal or va-*jy*-nal), va-*ri*-ola (*i* long), wormi-*a*-na, *xiph*-oid, yeast (*yeest*), yolk (*yolk*, *o* long, or *yoke*), *zin*-giber (genitive, zin-*gib*-eris), *g* like *j*; zy-*go*-ma, (*y* and *o* long, Dunglison and Webster; according to Walker's rule, it should be *zyg*-oma, *y* being short and accented, as in the original Greek).

It is not to be supposed that the above list embraces all the terms that could be cited in this connection. It is, however, sufficiently exhaustive to direct the attention of the reader to the subject, to show him its vastness, and to give him an insight into the amount of incorrect pronunciation common amongst medical men.

Baltimore, Md.

KEEP THE HEALTH FORCE PURE.

In the *Pittsburgh Medical Review*, Dr. Munn, of Denver, makes an earnest plea for common sense methods in sanitation. "Fill the health office," he cries, "with *experts* in every line. Above all, give the head of the department the fullest liberty in naming or in changing his subordinates. He is the man held responsible for the success or failure of his administration. Do not tie his hands by forcing on him coadjutors who are distasteful or unworthy; who will, perhaps, attempt to degrade the department to a mere political side-show for the reward of bummers and corner politicians; who will waste on illegitimate or foolish expenditures the moneys that are needed for the proper, urgent and legitimate work of the department.

"If a city or town has been fortunate enough to get a good health officer he should be kept at all hazards. There should not be a change at the end of one or two years in order to give the position to some other fellow with no especial fitness for the work, just because he happens to hold different views in regard to the tariff or the ballot for negroes or free silver. Whatever is done in other offices, competent men should be kept in the health office. It is no new sentiment to express here that municipal administration is business, not politics, and to no other department is this quite so applicable as to that of public health."

How in the world did this Denver health officer ever get into the health force of that city? It looks as if there were no political bossism there. And yet he seems able to describe our Baltimore failings to a "t." We do not bother about negroes and the silver question, but we are very particular about the way a man behaves himself at the primaries.

Fortunately for the general welfare, every rascal, even the craftiest, ultimately overreaches himself and tardy justice prevails. It seems that the time for fatal blundering has come to the notorious Dr. Keeley. He has sued the London *Lancet* for libel, laying his damages at $100,000. The ventilation of the Keeley business in the English courts will doubtless be thorough, and will certainly be disastrous to the "cure." If Dr. Keeley would institute the same proceedings against the journals on this side of the Atlantic that have said unkind things about him and his business, he could supply himself with libel suits enough to last him well into the coming century.—*Pittsburg Med. Review*, September.

The Edinburgh Life Assurance Company has recently adopted what it calls an "Early Provident Scheme." This is a system of deferred insurance for children under which the insurance does not begin until the policy has been in force for 15 years, but in the event of death before the expiration of this period all premiums are returned. No medical examination is required, and the form of proposal is a very simple one. The rates are very low, only about one half of what would be charged for an assurance effected in the ordinary way, owing to the liability being so long deferred.—*Baltimore Underwriter.*

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BALTIMORE, OCTOBER 1st, 1892.

Editorial.

DIFFICULTIES OF MEDICAL PRONUNCIATION.

The original article of Drs. Crutchfield and Thomas presented in this issue brings to our attention this subject—a subject which ought to receive careful consideration from every physician who claims to be thoroughly educated. And just at this time, when the colleges are entering unitedly upon the three-term curriculum, such consideration is especially appropriate. Upon the teachers of medicine falls most heavily the responsibility of training medical men in correctness of pronunciation; for when a faulty method of pronunciation has been acquired by the young physician, it is not likely to be corrected during future life. Often the physician is unaware that he pronounces incorrectly; he has learned his habit of speech from his teachers, and has never thought of looking into a dictionary to find out whether he is right or wrong.

A great hindrance to the acquisition of exactness of medical pronunciation is found in the diversity of opinions which exists among scholars in regard to the sounds and accent which ought to be attached to the words of dead languages, especially of Latin. The editor has been successively trained in three methods —the English, the German and the Italian—and his pronunciation of Latin is now a mixture of the three, which gives very peculiar results sometimes. His private opinion is that the American had better stick to a method which he understands and which comes natural to him,—namely, the English—and let the foreigner make the best he can out of the "American Latin."

This diversity of scholarly custom affects medical speech more than that of any other profession, because there are more Latin words used in medicine than in other like departments of human study. It is therefore unfair to judge the physician severely in regard to his manner of uttering scientific terms.

Another great cause to diversity in medical pronunciation is the change which takes place in the utterance of words of foreign origin as they become naturalized in

our own language. All foreign words which are frequently used are likely to acquire English pronunciation, and even spelling. It is difficult to determine just when such a word ought to be recognized in American dress. In this matter dictionaries differ greatly. The average doctor, with his public obligations, cannot be expected to remember whether an *o* was long or short in Greek or Latin, or whether an *i* in the name of a disease is the representative of *i* or *ei* in those languages. He will probably in the long run pronounce it in the way that comes easiest to his organs of speech and sounds best to his ear, that is, according to the spirit of his own language. The doctor who completely anglicizes much-used Latin and Greek terms will simply be a little in advance of his times. The teacher of medicine, however, should know what the dictionary says, and be ready to give the reason for his accent and vowel-sounds.

We would urge upon the reader that he take the list furnished by Drs. Crutchfield and Thomas and compare it with his own speech, and with his dictionary. By all means let him get rid of such corrupt pronunciations as are an evidence of his want of knowledge of his own mother tongue.

OUR WEEKLY CHRONICLE.

Under this heading we propose to give, from week to week, a report of the progress of disease in the city, and of events of general professional interest. In carrying out our plan, we must solicit the interest of our readers, that they may supplement by their co-operation our own efforts to keep ourselves posted in whatever concerns professional progress in the city. Any communications, by postal or otherwise, appropriate to this column will be gratefully received and published in our own words, without the name of the sender, unless he specially desires his name published.

For the present week we note a falling off in the practice of north-central Baltimore, while the eastern and western sections seem to be subject to a considerable amount of disease. Among the diseases reported is an epidemic of impetigo contagiosa, which is reported both from east and from west, being most prevalent probably among the poorer classes of children. The half-dozen or dozen ill-filled vesico-pustules or blebs on the face and hands, of finger-nail size, drying into crusts which seem "stuck on" over shallow unhealthy-looking ulcers, are quite characteristic of the disease, which, moreover, is contagious, is attended by but little itching, and tends to recovery. The disease in its epidemic form needs further study, especially in its relations to vaccination, which it frequently follows. We hope that some of our readers will furnish us a record of this epidemic, noting particularly any deviations from the regular type and any connection with vaccination. It is to the interest of medicine that every epidemic should be recorded in literature, if only for future study by classifiers of disease.

The trial for libel in homœopathic circles has excited some interest in the profession at large. We sincerely sympathize with those who honestly believe in the principles of Hahnemann, being influenced by parental training or by inabil-

ity to take a wider view of therapeutic science, and we wish they might separate themselves from those who profess them for motives of gain, and be in some way reconciled to the great body of physicians. The name under which they march is the great hindrance, there being often but little difference in practice. Any broad-minded physician would associate freely and cordially with one who, after a thorough education, chose, within safe limits, to follow any methods of practice he thought best. There are few if any homœopathic practitioners here who would let the theories of Hahnemann hinder them from giving any medicine with which they are acquainted, in any dose they thought necessary to control the disease.

The trial is a lesson to onlookers in regard to the loathsomeness of factional spirit, and the desirability of so living and speaking in private that unexpected cross-questioning in court may not put us to open shame.

Reviews, Books and Pamphlets.

An American Text-Book of Surgery for Practitioners and Students. By Charles H. Burnett, M. D.; Phineas S. Connor, M. D.; Fredrick S. Dennis, M. D.; William W. Keen, M. D.; Charles B. Nancrede, M. D.; Roswell Park, M. D.; Lewis S. Pilcher, M. D.; Nicholas Senn, M. D.; Francis J. Shepherd, M. D.; L. A. Stimson, M. D.; William Thomson, M. D.; Collins Warren, M. D.; and J. Wm. White, M. D.; Edited by William W. Keen, M. D., LL. D.; and J. William White, M. D., Ph.D. Profusely illustrated. Philadelphia: W. B. Saunders, 913 Walnut St. 1892. Royal octavo; pages 1209; cloth; $———

The aim of this handsome work is to present to the profession a text-book on surgery which shall be at once concise and comprehensive and at the same time essentially American in its teaching. That this has been accomplished is sufficiently shown by the high positions held by the authors, and is confirmed by a review of their work in the volume before us.

The editors represent respectively the Jefferson Medical College of Philadelphia and the University of Pennsylvania. By other members of the staff of authors the following teaching faculties are represented: Philadelphia Polyclinic; Medical College of Ohio and Dartmouth Medical College; Bellevue Hospital Medical College of New York; University of Michigan; Medical Department University of Buffalo; New York Post-Graduate School and Hospital; Rush Medical College, Chicago; McGill University of Montreal; University of the City of New York; Harvard University.

Each author is directly responsible for a portion of the work; yet each author's portion has been submitted to the revision of all the other authors, so that the separate portions are *combined into a single authoritative work by mutual criticism and revision.*

In view of such previous revision by so many eminent teachers we need not attempt to criticise the teachings embodied in the work. It makes a very attractive and yet handy volume for daily use. The illustrations are in every way excellent. The work is to be recommended to the attention of all medical men and students who desire a text-book of surgery up to date.

A New Pronouncing Dictionary of Medicine: being a voluminous and exhaustive hand-book of Medical and Scientific Terminology, with Phonetic Pronunciation,

Accentuation, Etymology, etc. By JOHN M. KEATING, M. D. LL., D., editor of the "Cyclopedia of Diseases of Children," etc., and HENRY HAMILTON, co-author of "Saunders' Medical Lexicon;" with the collaboration of J. Chalmers DaCosta, M. D., and Fred'k A. Packard, M. D.; with an appendix containing important tables of bacillus, micrococci, leucomaines, ptomaines: poisons and their antidotes, etc. Philadelphia 1892: W. B. Saunders, 913 Walnut St. Complete in large octavo volume of 818 pages. Cloth, five dollars, leather, six dollars net.

This volume has been in use by us now for several weeks. It embodies a very successful effort to furnish the physician and student with a good medical dictionary, and, more than this, with a guide to the pronunciation of medical words —a matter which has heretofore been sadly neglected by standard medical dictionaries.

We have tested the accuracy of the pronunciation by a long list of medical terms and find it very satisfactory. In words of doubtful accent the author takes generally that which seems to us most natural.

In some instances we have found no mark indicating the length and quality of doubtful vowel-sounds which should have been noted. Some terms (as names of unfamiliar plants of the materia medica) have been omitted, which ought to be given. We heartily recommend the work to our readers.

Materialism, and Modern Physiology of the Nervous System. By W. H. THOMSON, M. D., LL. D., Professor of materia medica and of diseases of the nervous system in the University of New York. Small octavo, 112 pages. Cloth, seventy-five cents. G. P. Putnam's Sons, New York, 27 West 23rd St., 1892.

This volume deals with the problem of the relations of brain tissue to the "consciousness," or the "I," or the "spirit" in man. The author combats the objections of certain modern philosophers to the independent existence of this "third something," which is not a modification of either "matter" or "force," and attempts to show that it is separate from and presides over the brain, which is its agent.

Some passages of the volume, in which analogies and similes from the sphere of scientific knowledge are brought in to illustrate the speculations of philosophy, are extremely beautiful. We are especially impressed by the views of the author in regard to the transfer of functions to higher seats as the intelligence of the animate world rises from species to species: by the plea for the central origin of language: and by the discussion of the relations of "consciousness" to sleep.

A Manual of Chemistry, Inorganic and Organic. With an Introduction to the Study of Chemistry. By ARTHUR P. LUFF, M D., B. Sc. (Lond.), M. R. C. P., physician to the out-patients in St. Marys' Hospital, lecturer on medical jurisprudence and toxicological chemistry (late demonstrator of chemistry) in the Medical School, etc., London. Illustrated with 36 engravings. Small octavo, pages 525. Cloth, two dollars. Philadelphia, Lea Brothers and Company. 1892.

This book is a guide to the study of chemistry for the use of students of medicine. The author designs in it to present to the student of medicine in a very concise form those portions of the enormous mass of chemical fact which directly or indirectly bear on medicine. His experience as a student and teacher of chemistry in the medical school mentioned have been his guide in the work which

he now presents to the medical public. It is a neat volume of very attractive appearance and we recommend it to the attention of our readers, especially those who want a concise and handy book.

Medical Progress.

TREATMENT OF SEA-SICKNESS.

In the *Lancet*, June 11, Dr Danvers takes up this subject of perennial interest. He says:

I would for clinical purposes group all cases into three divisions, according as (1) head symptoms largely predominate, (2) gastric symptoms predominate, or (3), the most common, those in which one finds head and gastric symptoms equally combined in minor degrees, and which I propose to speak of as mixed cases.

In the first group of cases one is generally called in the day after sailing—the time when the headache, etc., is most acute—and invariably finds the bowels have not acted for at least twenty-four hours and the urine is very scanty and high colored. Here I commence with a dose of calomel or an enema, and then give some form of nerve sedative, as bromide of ammonia with aromatic spirit of ammonia, antipyrin with chlorodyne, butyl chloral with compound tincture of chloroform, bromidia, or the effervescing hydrobromate of caffeine, which is my favorite remedy. Here I may mention an experience of nitro-glycerine for these cases. I was summoned on deck one afternoon to a passenger sitting in a chair with a very anxious, startled expression, and complaining of giddiness and cold hands and feet although it was an extremely hot day. His history was as follows: He was an hotel proprietor, and a phthisical patient who came out from England and stayed at his hotel had presented him with a sure cure for sea-sickness. The invalid had been given the prescription at home by the physician who ordered him abroad, but having had no occasion to use it on the voyage out, he presented the box intact to his landlord, who owned to being a very bad sailor. On this trip the landlord had recourse to the new remedy whenever he had any headache, and altogether had taken "about a dozen of the little chocolate pills" since sailing that morning. The box was labelled "Tab. nitro-glycerine, $\frac{1}{200}$ grain each. One to be taken at intervals when necessary." He said he had no headache; the pulse was decidedly intermittent. However, the recumbent position, hot stimulants, and handing the "cure" over to me, effectually tided him over by night. I have not felt justified in making any experiments with this "cure," and should feel obliged if any therapeutists would explain the *rationale* of the drug. Diet ought to be an important part of the treatment in these cases; but finding it nearly impossible to get patients to take anything, I fell back on alcohol—administered in the form of champagne, sparkling moselle, or gin and potash water, with a dry biscuit. My contention is that the patient's view of life in general is already extremely morbid, and under an entirely depressant line of treatment this would be aggravated. Finally, I would insist on the necessity of getting patients either up on the deck or in the ladies' boudoir at the earliest opportunity. Nothing is more fatal than to let them stew down in their cabins with only their melancholy thoughts for company. In cases of the second group I always begin treatment with a couple of glassfuls of warm water, which are promptly rejected, and then give a mixture composed of the following: carbonate of bismuth, bromide of potassium, dilute hydrocyanic acid, and spirit of chloroform; or bicarbonate of

soda, carbonate of bismuth with chlorodyne; either prescription effectually allays the gastric irritability. In the cases, however, where nature suggests the remedy by a craving for lemons or lime juice, I give small doses of this mixture: dilute muriatic acid with the infusion of cusparia and spirit of chloroform shortly before an attempt is made to take any food. I have also found cocaine tablouds useful here.

Alcohol in any shape is unsuitable for these cases, causing further congestion of the already irritable mucous membrane of the stomach, which is evidently wrong. I give as little fluid as possible, and ice to relieve the thirst. Diet should be of the blandest substances—cornflour, sago, or tapioca boiled in milk, *weak* mutton broth and beef-tea, not taken too warm. Broths or beef-tea as usually made by a cook are bitter, unpalatable fluids, so I always order them made weak, and then a body given by boiling down tapioca in them. These cases should not be interfered with too soon, as the vomiting is undoubtedly nature's curative effort on a system overloaded with bile, produced by the series of farewell dinners and luncheons preparatory to sailing. A dose of white mixture (carbonate of magnesia, sulphate of magnesia, and essence of peppermint) in hot water the first thing one morning is a most useful finale. For the mixed cases I give soda and compound tincture of cardamoms or nitro-muriatic acid and gentian during the day with a pill of calomel, colocynth, and hyoscyamus at bedtime, all that is necessary to make them come up smiling to breakfast next morning. They have found their sea-legs by them. As regards diet generally, at first one always recommends plain grilled or cold meats, with toast or a dry biscuit, and some fruit, and for drink, weak tea with a slice of lemon (no milk), or whiskey, or brandy-and-soda. Coffee and cocoa as a rule do not suit. I must mention, however, that I have seen such a variety of foods and fluids taken as "preventives," with apparent success, that the conclusion is forced on me that each one's palate is the best judge of what suits.

DEATH HASTENED BY AN EMETIC.

An inquest was lately held in Macclesfield on the body of a man who had, according to his own statement to a publican, taken some sulphate of zinc, presumably in the rum he had just been drinking. The services of a policeman were called in, who administered a glass of salt and water, but this did not make the man sick. He then went home, and the next day at noon was found dead in the watercloset, a *post-mortem* examination revealing perforation of the stomach. The medical witness considered that death had been due to the effects of chloride of zinc resulting from the salt on the sulphate of zinc, and said he had been unable to find any similar case on record, and went on to say that had it not been for the treatment adopted the man would have lived. This appears to us to be very hard on the policeman, who did the most sensible thing he could under the circumstances. We would further observe that there is no likelihood that such a chemical change as is here surmised to have happened would take place. So far as the report before us goes there is no evidence that the man took sulphate of zinc; indeed, as he did not vomit, it seems highly improbable that he did take any considerable dose of that salt, and he may have taken the chloride instead, or any other corrosive poison, for there is no proof that it was chloride of zinc that caused his death.—*British Medical Journal.*

THE RAMBLINGS OF CHOLERA.

The history of cholera, as known to Europeans, begins with an epidemic in Ceylon in 1804. It is now known to be epidemic and nearly always prevalent in

Bengal. The deltas of the Ganges and Brahmaputra are regarded as the nursery and starting-place of the disease. Previously to 1817 cholera had been confined to the native Indian population. In that year it broke out in Calcutta, and first attracted the attention of Europeans, who at first believed it to be a new malady. It spread all over India, and in October it broke out in the army of Marquis of Hastings, at Bundelcund. In the army along with a large contingent of native troops were ten thousand Englishmen. Many of these died, and the disease continued with unabated fury until the army was removed to another place. Thousands of dead and sick were left behind, but the disease in the army disappeared. In 1819 the disease broke out in Ceylon, and was from there carried to Mauritius and thence to the coast of Africa. In 1820 the cholera spread over Asia and followed up the rivers into the interior of China. On the Island of Java 150,000 people died. Evidence exists that from the year 1820 to the present time Bengal has never been entirely free from cholera. In 1822 the disease first appeared in Europe. It reached the Persian gulf by vessels and spread in all directions from there, reaching the Caspian sea and going up the Ural river to Orenburg, in Russia, which was the first European town to be afflicted. In 1829 it reappeared at Orenburg, but no one could tell whence it came, though at the time it prevailed over a large portion of Asia. In 1830 the first serious outbreak in Europe occurred. It spread from Astrakhan up the Volga river, and broke out in town after town, reaching Moscow in September, where a memorable epidemic occurred. In 1831 it advanced from Russia into Central Europe. It reached Berlin in August. In October it appeared in Sunderland, Gateshead and Shields, in England, and produced great mortality. The previous summer it had been introduced among the maritime population of London, but disapeared without attracting any attention at the time. Early in the spring of 1832 it gained a foothold in London, and during the summer prevailed in the important seaport towns of the British isles. It was carried from Dublin across the Atlantic, and appeared simultaneously in June, 1832, at Quebec and Montreal. It followed up the St. Lawrence and lakes to Chicago, and also spread through the Atlantic States, being especially violent in New York. The next year it was in Cuba, and was from there distributed to the ports on the Gulf of Mexico. Spain was visited in 1834, and the disease spread to the cities along the Mediterranean. It left Europe in 1837 to reappear ten years later through the same gate—the Caspian Sea—spreading over Russia and prevailing in Constantinople. It reached Hamburg in September, 1848, and in December of that year broke out simultaneously in New York and New Orleans, having come over with immigrants. It continued to prevail in the East, but did not reach western Europe again until 1853, the year of the terrible epidemic at St. Petersburg. It reached London in July, and was epidemic the following year.

The next appearance was in 1865, coming, as was supposed, by the Mediterranean from Mecca and Jedda. In Paris 7,000 persons died in five months. A few cases occurred at Southampton in 1865, but the disease did not make any headway until the following year. The Prussian army in 1866 passed through a country where cholera had prevailed the previous year, and more soldiers died from the disease than were lost in the war with the Austrians. Between 1873 and 1875 there were several epidemics of cholera in Germany, but England and the United States have now enjoyed a long period of immunity.—*Baltimore Sun.*

THE DIFFICULTY IN DIAGNOSIS OF THORACIC ANEURYSM.

Several cases illustrative of the difficulties met with in the diagnosis of this

complaint are given by Dr. McAll Anderson, of the University of Glasgow, in the *British Medical Journal*, one of which is especially worthy of quotation:

On November 16th, 1889, a man, aged 36, a driller by trade, was admitted into the Western Infirmary complaining of hoarseness, cough, and expectoration. He stated that he caught a chill in the end of June, and two days afterwards he became hoarse; but, as his medical adviser could not detect anything wrong with the throat, he neglected it. Two months before admission cough set in, and shortly afterward it became so severe that he had to give up work; expectoration of a clear, thick sputum soon accompanied it. Since the onset of his illness he had been troubled with night sweats, but he never complained of pain. He suffered, however, from palpitation and shortness of breath, aggravated by exertion but relieved on sitting or lying down.

On examination of the chest the usual signs of consolidation at the right apex were discovered, and at the left there was prolongation of expiration and sibilant *râles*. The expectoration was frothy and muco-purulent, but contained no tubercle bacilli. The respiratory murmur was much weaker over the left than over the right lung. The heart sounds were normal, the heart was of normal size, and the pulse on the two sides of the body were equal. The left pupil was dilated and fixed, the fundus was normal, but the right optic nerve was pale and cupped at its margin. The voice was reduced to a whisper, and the cough was "incomplete," and laryngeal in character. On examination of the larynx the vocal cord was found to be paralyzed in the cadaveric position. The scars of old strumous ulcerations were numerous on the right side of the neck.

The case was evidently one of intrathoracic pressure, the cause of pressure being seated at the root of the left lung. An aneurysm springing from the back of the left side of the aorta was supected, but as there was evidence of old strumous mischief, the presence of enlarged and strumous glands was possible.

On the morning of February 4th, he was awakened by cough shortly after midnight, and sat up in bed. Very soon he spat up a mouthful of blood, and immediately thereafter blood gushed in torrents from his mouth, and he was dead in a few minutes.

On *post-mortem* examination a small aneurysm was found springing from the back part of the thoracic aorta just beyond the arch; it communicated by an oval aperture with the left bronchus. The aneurysm pressed upon the trachea and left bronchus, and stretched the left recurrent nerve.

This case was the most remarkable of all, in so far as there was a total absence of distinct physical signs, and it, as well as the other illustrations cited, shows the importance of an accurate knowledge and appreciation of the pressure symptoms of intrathoracic aneurysm.

MIDWIFERY IN INDIA.

In a recent Government report Dr. Lawrie gives some interesting particulars of the practice of midwifery and of diseases of women and children in the city of Hyderabad, where it is almost entirely in the hands of uneducated dhais:—

"To give an adequate idea of the barbarities habitually practised by these women is impossible. We are able to judge of a few of them by the cases which from time to time came under our notice. In midwifery the treatment they adopt for cases of hand presentation is either to take a wisp of dry grass and set fire to it and burn the child's hand in order to make it withdraw it into the uteras, or else to wrench it off. If post-partum hæmorrhage occurs the patient is made to stand up against a wall and an old woman butts at her abdomen with her head, like a goat. Numbers of cases of peritonitis and injury of the ab-

dominal and pelvic viscera produced in this way come under our observation every year. The city dhais (midwives) have a superstition that breech presentations foreshadow evil to themselves and hence the child is always born dead from asphyxia in breech cases. The manner in which counter-irritants are employed in the shape of the actual cautery and powerful corrosives like the marking nut is truly shocking. Hundreds of young women are mutilated and die, or are rendered unfit for further existence as married women, by sloughing and faulty cicatrization of the external organs of generation, owing to the application of the cautery and the marking nut.

"One of the commonest diseases of Hyderabad is supposed, according to the uneducated hakims who flood the city, to be dislocation of the navel. So firmly rooted is the idea that this is a real disease that patients who have severe stomachaches and are persuaded that they are suffering from dislocation of the navel will submit cheerfully to the most painful treatment for its reduction. Quite recently a patient who was suffering from what was said to be an unusual intractable form of dislocation of the navel was so roughly pulled about by means of a rope passed round his waist and fixed securely by the ends to two pillars that he died of rupture of the spleen."—*Lancet.*

ANTIMONY AND COTO FOR DIARRHŒA.

In a recent Government report, Dr. Lawrie, of India, speaks (*Lancet*) as follows of these drugs:

The use of antimony in frequently repeated small doses in mucous diarrhœa depending on catarrhal inflammation of the small intestine in children is alluded to in the report.

"We now use antimony in combination with the liquid extract of coto in this disease with very satisfactory results. The extract of coto appears to be almost a specific in acute enteritis, nearly as much so as ipecacuanha is in acute dysentery. In young infants of four or five months old the extract of coto may be given in five minim doses every hour, made up with the mucilage of yusuf gool instead of water. Two or three minims of antimonial wine are added in each dose if the temperature rises above 101°F. Surgeon-Lieutenant-Colonel Ross, who was formerly civil surgeon of Delhi, first called my attention to the value of coto in mucous diarrhœa, and, judging from my own experience of its beneficial action, it ought to be widely known. No disease is more common among European children in India than acute enteritis and it causes an immense number of deaths every year. It is comparatively rare among Hindu and Mahomedan children. I believe this comparative immunity of Indian children is largely due to their habitual use of opium."

Medical Items.

Dr. Canfield has resigned his position in the University of Maryland Dispensary.

Yale College will next fall open its doors to students regardless of sex; its object being to admit graduates of "female colleges" and give them as good opportunities as could be found in Europe. This is the first of our great universities to make this change.—*Ex.*

There are districts in New York more densely populated than can be found in

any other city in the world, forming, many of them, great centers of nationalities. A glance at the steps taken each summer by our Board of Health and district organizations to care for the sick poor during the summer months will be full of interest, showing the better side of humanity. The city is divided below the Harlem River into fifty districts, to each of which is assigned a physician, who receives from the city $200 for eight week's service.—*Charlotte Med. Journal.*

At the meeting of the American Gynæcological Society, in Brooklyn, N. Y., September, 20, 21 and 22. Dr. J. Whitridge Williams, a rising young physician of this city, was unanimously elected to membership. Dr. Williams is the youngest member of the Society and should feel highly complimented, as the younger members of the profession are not, as a rule, admitted.

A young doctor, wishing to make a good impression upon a German farmer, mentioned the fact that he had received a double education, as it were. He had studied homœopathy, and was also a graduate of a "regular" medical school. "Oh, dot vos noding," said the farmer. "I had vonce a calf dot sucked two cows, and he made noding but a common schteer, after all."—*Ex.*

Drs. W. E. Moseley, W. T. Howard, B. B. Browne and H. P. C. Wilson, were in attendance at the meeting of the American Gynæcological Society, held in Brooklyn, N. Y., September 20, 21 and 22. These gentlemen express themselves as being much pleased with the hospitality extended to them by the different medical societies of Brooklyn and New York cities.

A leading jobber of Boston said: "I know of my own knowledge that there is in New York a large whiskey concern which is shipping quantities of whiskey into Maine as Jamaica ginger. The best ginger is prepared with French brandy usually. It is essential to the obtaining of the strongest medicinal effect that there should be a large percentage of alcohol in the tincture. It is impossible to retain ginger in solution without a very considerable proportion of alcohol and obtain the effect intended as a curative, but by lessening the amount of the ginger and increasing that of the spirit the whiskey dealers are enabled to evade the law, and the quantity of bottles of Jamaica ginger which they put out for these prohibition towns and the State of Maine is said to be simply enormous."—*American Druggist.*

Dr. T. Hayward Hays, well-known in Baltimore as medical missionary to Siam, whither he was sent by the Presbyterian Board of missions six years ago, has recently been presented with a handsome gold watch and chain, with locket, by the King of Siam. The watch bears the King's monogram inlaid with diamonds. The gift was for successful professional attendance in the King's family at the birth of the King's youngest son. The Bangkok *Times* says that on July 25th Dr. Hays was opening a sealed tube half full of nitrite of amyl, and tapped the head, whereupon the contents, which had expanded through the heat, exploded, knocking the Doctor down and cutting his hands and face.—*Baltimore Sun.*

Gonorrhœal infection of the genitals of baby girls probably occurs in the same way as that of the eyes, namely, during the passage of the child through the cervix and the vagina. Epstein believe that this occurs more frequently than is commonly supposed, and that a part, at least, of the cases of gonorrhœal vaginitis in somewhat older girls are the result of an overlooked and neglected infection at birth. Epstein makes the reasonable suggestion that with gonorrhœal mothers, care should be taken to prevent infection of the infant's vulva as well as its eyes.—*Ex.*

In 1832 an American physician proposed to check the diarrhœa of cholera by plugging the anus with a soft velvet cork. An English physician, even more ingenious, proposed to keep the blood circulating by putting the patient on his back on a board, and see-sawing him up and down at the rate of eighty to one hundred times a minute. Another physician advised bleeding, turpentine, and cool drinks; still another thinks the disease one of the spinal cord and sympathetic, and plasters the back with ice-bags.—*Med. Rec.*

A model of ocean currents is to be exhibited at the World's Fair which will possess great practical value. This model, which is a huge scientific tank, is made to represent the surface of the earth spread out on an area of about thirty feet square, the ocean and seas being shown by actual water. Small streams of water are ejected through pipes under the model, so that the whole body of water moves exactly as the ocean currents move. The direction of the currents is shown distinctly by a white powder on the surface of the water. Near the model will be placed a large map giving the fullest details of the force, volume and direction of the ocean currents.—*Baltimore Underwriter.*

At the Paris Maternity there are born annualy an average of 400 infants before term. As may be imagined, the mortality amongst this premature addition to the infant population was very great before the introduction of the system of incubation combined with "gavage." The beneficent effect of this system may be gathered from the perusal of the following figures. Mortality in the ante-incubator period:—Infants born in the sixth month, 100 per cent.: at six months and a half, 78.5 per cent; at seven months, 61 per cent.: at seven months and a half, 46 per cent.; at eight months, 22 per cent.; at eight months and a half, 12 per cent. The incubator and "gavage" have converted these figures into 84, 63.4, 50.2, 23, 11.2, and 4 per cent. respectively. Comment is superfluous. It is, however, only right to recall the predominant part taken by Professor Tarnier in popularizing this method of saving to the world a not inconsiderable number of human beings who would, under the old *régime*, have had hardly the time to make their bow to the family circle before quitting it forever.—Correspondent of the *Lancet*.

I think that the influence of music has not been utilized in the treatment of disease as it might have been. Whoever has visited the theatre or the opera must be familliar with the soothing and generally pleasant influence that music possesses, and all the more so if some contrivance has been made so as to have the musicians out of sight and that the music may sound as if at a distance; the distant sounds of bells, of a waterfall or of singing is alike pleasant and soothing, and all the more so if it be heard at night or in quiet places which invite to meditation. An ancient writer says of music: "It makes a child quiet; the nurse's song, and many times the sound of a trumpet on a sudden, bells ringing, a carman's whistle, or a boy singing some ballad tune early in the street, alters, revives, recreates a restless patient who cannot sleep in the night." I am persuaded that in some form and in suitable cases, of which the physician would be the best judge, music might be made more serviceable in treatment, provided it were judiciously employed and kept from assuming the garb of quackery or mystery, and in this manner becoming ridiculous. Music was employed, as we know, so far back as the days of the first Israelitish king, for the Scriptures state: "When the evil spirit from God was upon Saul, David took an harp and played with his hand; so Saul was refreshed and was well, and the evil spirit departed

from him." It is strange, therefore, that in this day it has been so greatly neglected."—Dr. Dale, in *Lancet*.

We are confident that there is a large margin for philosophic doubt whether babies do suffer pain. Even the advocates of the pain theory search high and low, in and out the screaming baby, to discover the locality of the supposed pain, and the result is eminently uncertain; the final method of pacification has no connection with the conjectured pain, and almost entirely consists in distracting the attention. But this is equally compatible with the theory of crying for fun and ceasing at the prospect of greater fun. Crying and pain are so associated in the popular mind, that it requires an effort to disconnect them; but if a mistaken sympathy should be philosophically repressed, and the situation regarded with calm reason, it would make a revolution in babydom. Instead of anxiously pacing to and fro with a screaming child, and doing all she knows to stop the clatter, a philosophic nurse would quietly place the baby on a sofa to enjoy its screaming until some other whim seized it. It would be a great relief to be able to listen with equanimity to the woes of the baby, to hear its squalling without responsibility, to be freed from administering most trying sympathy, and to escape the hopeless task of pacification. It would place baby life in a more cheery aspect. We should recognize a screaming baby as a baby of resource—that it varied its pleasures and enjoyments; that it preferred muscular exercise to indolent rest; in fine, that it was a baby of spirit. In the end we might even encourage the baby to cry in order to promote health and sturdiness. Thus, half the annoyance, the worry and the tyranny of babies would disappear.—*Ex.*

At the Fifth Annual Meeting of the American Association of Obstetricians and Gynecologists, at St. Louis, Dr. George H. Rohé, of Catonsville, read a paper on "the relations of pelvic disease to psychical disturbance in woman." The author pointed out the frequency with which bodily conditions influenced mental states. Thus a torpid condition of the intestines, Bright's disease, putrefactive processes in the intestinal canal, etc., might give rise to melancholia and other disorders of the mental functions. It is not irrational to suppose likewise that diseases of the female sexual apparatus would have not inconsiderable influence in the production or perpetuation of mental disorders. As a contribution to the knowledge of the subject the following report was submitted: In a hospital containing 200 insane women, 35 were subjected to vaginal examination and 26 found with evidences of pelvic diseases. In 18 of these the uterine appendages were removed with the following results: Sixteen recovered from the operation and two died. Of the 16 recovered, three have been discharged from the hospital completely restored, both physically and mentally. In 10, considerable improvement followed the operation in both physical and mental conditions, and in 3 the operation was of too recent a date to allow any definite expression of opinion. The mental disorder present in the 18 cases was melancholia in 6 cases, simple mania in 1, puerperal mania in 4, hysterical mania in 1, periodic mania in 2, hystero-epilepsy with mania 1, and of epilepsy with mania in 3. The author, basing his opinion upon his experience, concludes as follows: "The facts recorded demonstrate, first, that there is a fruitful field for gynecological work among insane women; second, that this work is as practicable and can be pursued with as much success in an insane hospital as elsewhere; and third, that results obtained not only encourage us to continue in the work, but require us, in the name of science and humanity, to give to an insane woman the same chance of relief from disease of the ovaries and uterus that a sane woman has."

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CONTENTS

ORIGINAL ARTICLES.

Laparotomy for Retroflexion of Uterus and Prolapse of Tubes. Reported by Laura Cook Hann. 1079

A Case of Convulsions Following Scarlatina. By A. K. Bond, M. D. 1081

EDITORIAL.

The *Lancet's* Sanitary Crusade. . . . 1084

What the "Ions" do in Salt Solutions. . . 1085

Our Weekly Chronicle. 1085

REVIEWS, BOOKS AND PAMPHLETS. . . . 1086

MEDICAL PROGRESS.

The Need of Culture in Medicine.—Adhesive Straps in Diseases of the Chest.—Surgical Treatment of Puerperal Peritonitis.—To Keep the Mouth Sweet.—The Crude Massage (or "Malaise") of the Natives of India.—Sensitive Teeth.—A Hint in Treating Asthma.—Varicella and Herpes.—Phenyl-Hydrazin Test for Sugar in Urine.—Case of Dislocation at the Elbow Joint.—Galvanism for Fibroids.—Iron Salt in Diarrhœa.—Epithelial Pearls in the Mouths of New Born Children.—Snake-Bite in Australia.—Treatment of Convulsions by Compression of Carotid.—Extirpation of Cancer of the Stomach.—The White Corpuscles as Protectors of the Blood.—A Valuable Remedy in Dermatology. 1087

THERAPEUTIC RECOMMENDATIONS. . . . 1098

MEDICAL ITEMS. 1098

Original Articles.

LAPAROTOMY FOR RETROFLEXION OF UTERUS AND PROLAPSE OF TUBES.*

REPORTED BY LAURA COOK HANN,

Clinical Assistant.

The patient, Addie S., was twenty-four years of age, married six years, no children; excessive dysmenorrhœa and convulsions every month. Had had a previous operation on cervix, the nature of which could not be ascertained. The diagnosis was retroflexion and adhesion of the uterus; the tubes and ovaries were prolapsed and also adherent.

The patient, before being placed on the operating table, had received a bichloride bath, care being taken to get the umbilicus and all parts perfectly clean. She had also had an antiseptic vaginal douche and a hypodermic injection of morphia, gr. $\frac{1}{4}$, atropia, gr. $\frac{1}{100}$.

To keep the lower extremities warm they had been enveloped in blankets; her clothing and the blanket covering her were folded back far enough to give the operator room to work, and a towel saturated with bichloride solution was placed over them. The catheter was used. The pubes was shaved and thoroughly washed again and a towel wrung out in the antiseptic solution placed over the vulva.

*In the service of Prof. B. Bernard Browne, M. D., Nov. 6, 1891, at Good Samaritan Hospital, Baltimore.

An incison, about two and a half inches long, was made in the median line about one inch above the symphysis pubis. The operation confirmed the diagnosis. The exudations had become so thoroughly organized that it was necessary to lengthen the incision to allow room to work; the process of breaking up the adhesions was extremely difficult and tedious, all of it being done with the fingers in order to lessen the liability to hæmorrhage. The tubes were in such a diseased condition that they tore loose from the uterus and broad ligament: coming out, the right in one, and the left in two pieces.

When the uterus and ovaries had been wholly freed from all adhesions the ovaries were brought through the incision, ligatured off, and removed.

The method of ligating employed was to pass the threaded pedicle needle through the broad ligament, as near the uterus as possible, and have the assistant thread the ligature of braided silk through the loop, keeping hold of both ends. The needle was then withdrawn, carrying with it the double ligature. This was looped back over the ovary in the present case (but it usually includes the tube), and brought down to the level of insertion, and the loop was placed between the ends of the ligature as in Tait's method. These were then tied, the surgical knot being used. This makes a very firm ligature; tranfixing the pedicle and using the loop prevents slipping. The stumps of the tubes were then tied to prevent secondary hæmorrhage. Thus far the operation had taken fifty-five minutes.

There was some hæmorrhage from the torn surfaces. To check this and wash out the abdominal cavity, hot water was used—poured in from a pitcher. The operator preferred this method to the use of the fountain syringe, because it washed out the pieces of dead tissue better.

He remarked in passing that there had been some objection made to ovariotomy on the ground that it unsexed the patient; and that he had been one of the first to answer this objection, by showing that a woman in the condition in which this patient was when she applied for operation could not conceive, and that even if she were still menstruating monthly the existence of the flow did not prove that ovulation still took place.

The cavity having been thoroughly washed out, a glass tube was introduced, and through this the water which remained in the abdominal cavity was drawn off by means of a syringe. The sutures were then inserted with an armed needle, care being taken to include all the parts, the assistant threading the silk-worm-gut in the loop. There were seven of the latter. The operator cautioned the students about pulling sutures back and forth to make the ends of the same length, as there was danger of septic germs being thus carried into the wound. In tying, it is only necessary to have all surfaces in apposition. If the sutures are drawn too tightly, there will be danger of strangulating the tissues. Stitches should be removed as soon as union takes place, usually about the third or fourth day. The tube, which was held in position by a silk suture, acted a double purpose—as a splint on which the uterus could rest, thus preventing further adhesions; and as a drain for the cavity.

The surface was carefully dried and a dressing of gutta percha, which had been rendered antiseptic, was placed over the wound, an incision having been made through it for the passage of the tube. Next came a layer of antiseptic gauze arranged in the same way; then cotton was built up to keep the pressure off the tube. A small strip of antiseptic cotton, twisted, was placed in the tube to aid in drainage—the fluid passing up by capillary attraction. This obviates frequent removal of bandage and draining by use of syringe. A broad double bandage of muslin was used. This was placed well down over the hips and drawn moderately tight. The time consumed in the operation was one hour and a half.

The operator told the students that most cases of retroflexed uterus were accompanied by adherent ovaries and tubes.

The tube was removed on the second day, and the stitches on the morning of the fourth day. The temperature of the patient never exceeded 100° F. Her pulse reached 120 on the second day, and then gradually fell to the normal.

The diet consisted of hot water every two hours until the second day, when she was given milk. On the seventh she had solid food. Hypodermics of morphia were given every night, and during the day, if necessary, to quiet pain. On Nov. 20th she was brought again before the class. The wound had healed nicely, leaving only a small scar. She was discharged, well, on Nov. 25th, having been in the hospital nineteen days.

A CASE OF CONVULSIONS FOLLOWING SCARLATINA.

BY A. K. BOND, M. D.,

Lecturer on Diseases of Children and Dermatology, Baltimore Medical College.

I saw the patient first at the time of the onset of the convulsions, on April 10th, 1892. She was a dark-haired, well-developed girl, 19 years of age, who was in Baltimore on a visit to relatives, her home being in Virginia. She had never previously manifested any tendency to disorders of the kidneys. It was said that her father was afflicted with some slight "kidney trouble," but I could not connect the symptoms given with any definite disease of those organs.

About one month before my first visit the patient was attacked by scarlatina, which ran a course natural to it; there being no indication of kidney complications noted, except that the urine had been a little cloudy soon after the appearance of the eruption, clearing up in a few days. There was every indication of normal convalescence from the disease, the patient seeming well and having lost little flesh.

On the 8th and 9th of April there was a sudden change of weather from warm to cold, which must have had an injurious influence on the patient, although she was not known to have exposed herself to chilling. On the 9th she began to suffer from nausea and headache, for which some mild remedy was administered. At 3 o'clock on the morning of April 10th I was called in haste by her father, as her physician, Dr. Taneyhill, was suffering from severe indisposition and was unable to respond to his call (though able to advise with me in the case). I learned that

the patient had gotten out of bed to urinate, the urine being apparently as free as normal, and was found in convulsions on the floor. The tongue had been severely bitten. I watched by her bedside for three hours, during which time convulsion rapidly followed convulsion (perhaps a dozen in all) without return of consciousness. There being another medical assistant present, I took the opportunity of carefully observing the character of the convulsions, in order to learn how they differed from the other cases (especially epileptic) which I had recently attended. The cycle of the convulsive seizure was about as follows: The patient would be lying on her back in deep unconsciousness; the eyes, which had been closed, or partly closed, would then open with a fixed stare; the head would next be drawn upwards and to the left, with tonic contraction of the face muscles; the face would next rotate over to the extreme right (the chin being still far from the sternum), and the arm and leg of the right side would be thrown into severe clonic spasms, the mouth working also in rapid clonic spasms; these spasms would soon cease, except the working of the mouth, which continued for several minutes after the cessation of the arm and leg movements; the passing off of the convulsion would be marked by repeated efforts to blow out froth from the mouth and apparently from the larynx, the respirations being now a little slower than normal; finally the patient would sink into stillness, as at the first, until another convulsive cycle set in.

Chloroform vapor was freely administered, but although after repeated inhalations covering an hour or more the tendency to convulsive seizures ceased, I could not perceive that the individual convulsions were shortened or made milder by it; they certainly were not "jugulated" by it after they had at any time fully set in. After deep anæsthesia had been induced by the vapor, it would be withdrawn and in about ten minutes the eyes would fix, and another convulsion would begin. During the time of my visit the patient's face continued pale throughout both convulsions and intervals of quiet. There was no cyanosis at any time; the heart-beat was normal or a little more frequent than normal. The skin was dry and continued so in spite of the application of hot leg-baths and hot bottles to the feet. No other drug than chloroform was used at this time.

At 6 A. M., the convulsions had ceased and the patient had apparently sunk into deep coma. Promising to call in a few hours, the physicians left, after ordering that one grain of calomel in powder should be placed on the tongue hourly for two hours, one-tenth of a grain hourly afterwards; and that the hot baths to the feet, and hot bottles, should be continued.

At 10.30 A. M., of the same day (April 10th), I returned, and was greatly surprised to learn that the patient had regained consciousness sufficiently to recognize her father. She had no recollection of what had occurred during the night. There were no more convulsions during the continuation of the case. The skin was still persistently dry. The calomel was stopped about midday, April 10th. I gave a steam bath from hot bricks, but it did no good, the skin remaining dry. There was nausea during the day with repeated vomiting, but it seemed to be ex-

cited chiefly by the taking of water, milk, or beef-tea. In the afternoon I ordered half-drachm doses of potassium bitartrate much diluted in water. This was retained and the patient steadily improved, becoming more and more intelligent. A large girdle-poultice of flaxseed meal about the loins, covered with oiled silk, seemed to be of great benefit.

The patient steadily convalesced, and on April 21st was able to go about the house again.

I have judged the foregoing case worthy of record, because it presents several features of especial interest.

1st. It corroborates the oft-repeated warning of medical writers that an apparently normal course of convalescence after scarlatina is no guaranty that uræmic convulsions may not be excited at any time by sudden changes of weather, etc. I diagnose the convulsions as "uræmic" because they occurred in convalescence from scarlatina, and because the antecedent headache and nausea as well as the persistent dryness of the skin and the character of the convulsions themselves pointed to uræmia.

2nd. The attack was not preceded nor accompanied by diminution of the excretion of urine, as judged by the eye.

3rd. I have never in epilepsy observed the recurrence of an orderly cycle, of successive involvement of different muscles of the two sides of the body, such as that described above; nor any such prolongation of the clonic spasms, especially of the parts about the mouth. The paleness of the skin throughout the attack was also an indication that the disorder was non-epileptic. Hysteria was excluded, because there was no indication whatever of its presence.

4th. The cessation of the convulsive tendency may perhaps be ascribed to the chloroform, which was repeatedly pushed to the farthest limit of safety, although it did not quiet individual spasms, nor prevent at first their rapid recurrence.

5th. The case teaches that in cases of this sort the physician should never lose hope of final recovery, even though fatal coma seems to have set in; but should persist in the use of innocent diuretic, aperient and diaphoretic remedies such as those mentioned. The gravity of the case seemed sufficient to justify the employment of heroic remedies, yet the outcome suggests that it is just as well that no dangerous remedies were applied, as they might have quenched the feeble spark of life which was struggling to a full flame.

BACTERIOLOGICAL DIAGNOSIS OF CHOLERA.

A demonstration on the bacteriological diagnosis of cholera was lately given before the Berlin Medical Society by Dr. R. Pfeiffer, who urged the systematic microscopical examination of the dejecta, which in certain cases is quite sufficient to establish the diagnosis, when the comma bacilli occur in an almost pure culture and form characteristic masses in flakes of mucus. In cases of doubt gelatine plate cultures must be made to decide the question. The methods thereby necessary to absolutely determine diagnosis occupy from twenty-four to thirty-six hours.—*Boston Med. and Surg. Jour.*

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BALTIMORE, OCTOBER 8th, 1892.

Editorial.

THE *LANCET'S* SANITARY CRUSADE.

This excellent representative of the medical profession of Great Britain is continually establishing new claims upon the gratitude of the public by its wise and earnest efforts to secure sanitary reforms in the great city of London. We know the benefits which resulted from its inquiry into the deplorable "sweating system." Now it turns its attention to the promotion of healthful conditions in the houses of the city. It realizes the fact, which must be evident to all observers, that a large percentage of houses in our great cities are unfit for human or even for animal habitation, by reason of imperfect drainage, lack of plumbing repairs, etc.

With a view to bringing this matter before the general public, the great medical weekly appointed a commission to inquire into "the law and practice of house-letting." Acting upon the information given by this committee, the *Lancet* published a report concerning the matter, suggesting certain remedies and asking for criticism from the public; and quite a hearty response was given by the lay press.

As the matter now stands, the suggestions before the public are:

That a clause guaranteeing the drainage should form part of the agreement in the letting of any house.

That arrangements should be made to enable any house-owner *who so desires* to register his house on books kept by the local city authorities as being in first-class sanitary condition (if after due examination it be found in such condition), and to receive from the sanitary authorities an official certificate to that effect.

That all lodging houses and hotels should be *compelled* to obtain such certificates.

It is to be hoped that the reform will be embodied in proper legislation and carried out in London. Some such provision is greatly needed in Baltimore. Its physicians who deal with the poorer classes in the community have frequently

to attend in houses whose unsanitary drainage is at the bottom of the patient's illness. They urge families to remove from these unwholesome houses, but this cannot be done, because the families do not know where to find healthful lodgings at the rental which they are able to pay.

We willingly endorse the sentiment of the *Lancet* that "when local authorities awaken out of the slumber with which their eyelids are still heavy, the public may expect to witness the dawn of a new day for sanitary science."

WHAT THE "IONS" DO IN SALT SOLUTIONS.

Those who wish to acquaint themselves with a theory which is now receiving much attention, may turn to our column of "book reviews" and read an extract we have made from the new chapter added in the fourth edition of Professor Remsen's Theoretical Chemistry. Being of a philosophical tendency we have always found especial interest in this side of chemical science: the new theory now presented is very beautiful. Under its teaching, the drop of pure water becomes a scene of most intense activity through which the "ions" flash incessantly under the subtle and ever more wonderful impulse of electricity. Truly, as Professor Remsen assured us many years ago in his lectures, the progress of chemistry does not take away from the mystery of the Creator's works, but only adds point to this mystery.

OUR WEEKLY CHRONICLE.

Practice remains dull over the city as far as reported. In fact, the general practitioner has found unusual opportunity for side pursuits this summer. By some this slackness in medical work is ascribed in part to the more elegantly equipped dispensaries in which hundreds of well-to-do citizens obtain free treatment.

Some of our physicians are found daily at the "homœopathic libel trial" in the City Court, which still continues at the time we go to press. We propose to give a comprehensive sketch of the trial after the court has passed upon its merits. We have found occasional attendance at this trial of great benefit. It is well for every physician to acquaint himself with the methods pursued in suits at law involving his profession. What steps should be taken in expelling a member from a medical society in such a way as not to expose the society to libel suits; what sort of testimony is likely to be admitted under the ruling of a court; how tedious and time-consuming a suit may be to the physicians involved; what hopeless confusion a medical witness may be thrown into by the persistent nagging of a skillful lawyer: all these points are clearly illustrated or suggested by the trial before us.

The introductory lecture at the Baltimore Medical College was given by Prof. Robt. Johnson, Sept. 30th. The ceremonies took place in the new lecture hall on the second floor of the still unfinished college building on the corner of Madison Street and Linden Avenue. The hall was gaily decorated with flags, mottoes and

flowers. The lecturer discoursed in eloquent yet scientific terms of the manner in which Nature, unaided by art, sometimes works wonderful cures, both in medical and in surgical disorders of the human body. The large hall was well filled with students, who have thronged to the college in far greater numbers than ever before. Its acoustic properties prove to be excellent, a matter of much congratulation to those who have planned the new building, and to the energetic dean, Dr. Streett, who has labored faithfully in its advancement. The teaching force of the college has within a year been augmented by the addition of Dr. Robert W. Johnson, Professor of Surgery; Mr. W. B. D. Penniman, Lecturer on Chemistry; Dr. J. G. Wiltshire, Lecturer on Topographical Anatomy; Dr. R. B. Warfield, Demonstrator of Anatomy; and Dr. J. M. H. Rowland, Instructor in Latin. This last-mentioned appointment has been rendered desirable by the adoption of the three-year curriculum.

Reviews, Books and Pamphlets.

The Principles of Theoretical Chemistry with Special Reference to Chemical Compounds. By IRA REMSEN, Professor of Chemistry in the Johns Hopkins University; 4th edition, thoroughly revised. Philadelphia: Lea Bros. and Co., 1892; 8vo., pages 322; cloth.

The excellence and popularity of this work is sufficiently attested by the fact that it has in a few years reached its fourth edition and that it has been translated into German and Italian. It does not aim to cover the ground of the ordinary text-book of chemistry for beginners in school or laboratory, but treats of the "facts and speculations which have to deal especially with the problem of the constitution of chemical compounds." The object of the author is "to help students to get clear ideas in regard to the foundation of chemistry." The present edition differs from former editions in that it is brought thoroughly up to this date, and includes a short chapter on solutions.

No one who takes an interest in the facts which the human mind has discovered in regard to the wonderful laws which control the incessant changes of the chemical world and in the steps by which these laws have been learned, can afford to neglect the perusal of this volume. In the additional chapter referred to we are led to a most unexpected conception of the conditions which exist in ordinary inorganic salt solutions. These apparently peaceful liquids are presented to us as being perhaps the scene of most intense activity. The salts dissolved may be considered as split up to some extent into their constituent "ions" (the factors into which they resolve under the influence of electrolysis) by the action of the water—the greater the dilution, the more wide the separation of ions; the ions remain in the solution highly charged with electricity. They are not at rest, but continually moving through the solution: and as they move they come into contact with each other, and combinations and decompositions are constantly taking place. With the passage of a current from an electrical battery through the solution the ions are directed by it to their appropriate poles, and, arriving, discharge their electricity and become free. This hypothesis of Arrhenius is growing in favor with chemists.

Essentials of Diagnosis (being number 17 of Saunder's Question Compends). Arranged in the form of Questions and Answers, Prepared Especially for Students of Medicine. By SOLOMON SOLIS-COHEN, M. D., Professor of Clinical

Medicine and Applied Therapeutics in the Philadelphia Polyclinic; and Augustus A. Eshner, M. D., Instructor in Clinical Medicine in the Jefferson Medical College and in the Philadelphia Polyclinic. With 55 illustrations, some colored. Philadelphia: W. B. Saunders, 913 Walnut Street, 1892. 8vo., pp. 359; $1.50 net.

This handy volume seems to us to be excellently adapted to its purpose. It furnishes a concise review of the whole field of medical diagnosis in such a way that the student may find "in a nut-shell" the essential characteristics of each disease, while the practitioner of standing may in a moment refresh his memory in regard to the diagnostic points of less familiar disorders, according to the most recent advances of science. The illustrations are good.

Medical Progress.

THE NEED OF CULTURE IN MEDICINE.

We may well clip a few paragraphs from an editorial in the *Lancet*, September 17, touching a recent article by the late Sir Morell Mackenzie on "Culture and Professional Success:"

All educational methods are being subjected to the most stringent scrutiny, and the medical profession has been, and still is, engaged in revising its curricula and extending its period of study. Hence, an article like that cited, raising the great question how far general or "liberal" culture, as contrasted with special, technical, and professional education, is conducive to professional efficiency and success, is worthy of careful attention. The article is strongly in favor of a wide general culture as the best preparation for the more special training which every profession demands from those who aspire to enter it. The author's grounds are various, but they may be summed up under two heads: first, that such culture confers breadth and flexibility of mind and renders the acquisition of special knowledge easy; and, secondly, that it develops a knowledge of human nature, and hence assists in enabling us to treat our clients or patients, not as mere "cases," but as complex, sensitive, and highly organized men and women.

The greatest enthusiast for science will hardly affirm that chemistry, physics and biology afford a sufficient basis for an all-round intellectual development. They are no doubt most important, but their successful prosecution would still leave the student ignorant of the history of his race and of many of the highest and noblest achievements of the human intellect. In medical education we desire, with as little waste of time as possible, to bring trained and disciplined minds to bear on the problems of disease, and the question is in what manner this can be best effected. Many will accept this putting of the case and will ask with derision how the Differential Calculus, the subtleties of Greek grammar, or the Categories of Kant are likely to be helpful. A sneer of this kind, however rhetorically effective, is not conclusive. The medical student needs strength and grasp of mind; the capacity to note resemblance and differences; the power of determining what amount of evidence is sufficient to warrant a given conclusion; some capacity of reading character, so as to estimate correctly a patient's statement and to eliminate the personal equation. He needs to be cautioned against haste, inaccuracy, prejudice and preconceived opinions, fallacious reasoning, confused or contradictory ideas, want of tact and many other things. These are formidable requirements, and the question is whether they can be met by any process less tedious and troublesome than that involved in a good preliminary education. The great danger of medical education at the present day is that raw

youths with wholly unformed minds and destitute of any correct ideas regarding observation, evidence, and reasoning, should be set to dissect snails, mussels, and frogs, to look down microscopes, and to handle test-tubes, and come to imagine that little else is necessary. If such methods extensively prevail, we believe the results would be quite as disastrous as those which flow from an excessive devotion to the Greek digamma or the higher geometry. Cardinal Newman says in one of his works that we have ample proof that the old methods of instruction by means of the classical languages and mathematical studies are capable of producing flexibility and grasp of mind, and that we have no proof that any other methods are adequate for this purpose.

Apart from purely professional work, we have to consider how best we can promote that mental attitude which helps the practitioner to understand his patient not only as a subject of disease but as a human being. In the article alluded to above it is justly observed that professional success depends not only upon the power of giving good advice, but upon the capacity of so influencing our patients that they will be inclined to follow that advice when given. Many of the greatest practitioners of medicine have a magnetic influence in this way; but for those not thus exceptionally endowed there is no means of acquiring this power so likely to be successful as a wide knowledge of different subjects—in other words, a good all-round culture. This should enable its possessor to understand different types of mind, to enter into their points of view, and to sympathize with their various difficulties and apprehensions.

ADHESIVE STRAPS IN DISEASES OF THE CHEST.

In an article (*Cincinnati Lancet-Clinic*, September 10), entitled "Some Points in Chest Therapeutics," Dr. Brown, of Hillsboro, O., writes:

While I have said that the consideration of tuberculosis is not a part of this paper, I beg to make the following suggestions in regard to the treatment of tuberculous cavities, namely, by the adhesive strap method. It is well known, if I mistake not, that the rent in the lung which gives rise to pneumothorax usually occurs in the lower part of the upper lobe, and particularly is this the case on the left side.

Many instances of pneumothorax, as we all know, take place during the progress of tuberculous disease, and nearly always take place through the thin wall of an old cavity somewhere in the upper lobe of one of the lungs, and, I think, in about seventy per cent. of all the cases, on the left side.

Therefore, knowing as we do so accurately, where to look for dangerous cavities and what to expect when found, it plainly becomes the duty of all physicians to resort to any prophylactic treatment which gives promise of successful prevention of an imminent disastrous ending to an otherwise faintly hopeful case.

I think, in the adhesive straps one has a reliable and easily-applied preventive means.

As soon as the diagnosis has been made, the straps should be applied with strong pressure, thus bringing the walls into partial coaptation and holding them there until healing and contraction of the cavity have taken place. Leslie's adhesive plaster cut into straps about two inches wide and put on in the following manner will surely and certainly prevent and give marked comfort and support to the patient. Begin at a point three inches below the margin of the cavity to apply the straps, making the starting point the centre of the sternum. Ask an assistant to hold solidly the sternal end of the plaster, and then make strong and forcible traction as the other end is drawn directly around the body to the spine at a point opposite the beginning, fasten it to the skin by gentle friction movements

from one end to the other before either doctor or assistant release their hold upon the respective ends. After that one is well secured, another can be applied above in like manner, and so on until the region is well strapped as far above the upper margin of the cavity as the beginning was below it. Then an additional one or two to cover over the margins of the plasters which have been left in close contact with each other, and the application is finished.

One can do no injury, no matter how much force is used in making the application, and the more snugly the plaster fits the more grateful the patient is for the relief obtained, which is always commensurate with the degree of force used in making the application.

The plasters should be replaced with new ones as often as they become ragged or get loose, until, by physical signs, you are able to demonstrate that the cavity has contracted.

In certain forms of pleurisy, I have come to regard the above treatment as almost a universal specific, the patient always expressing himself as having obtained quick and complete relief directly the plasters are put on.

In all forms of pleurisy, the plaster should rank among the most potent means of relief, but especially in that of dry pleurisy, which does not send its victim to bed nor bring with it an elevation of temperature, nor followed by an effusion, but in which constant annoying pains are being complained of and in which the pains are much increased on exercise and on the taking of a deep breath. In such cases a careful examination will reveal a low, dry friction sound in one or more places over the affected region.

Convalescence is immediately established and your patient is relieved of an otherwise tedious and painful malady directly you apply the straps and give him rest to the affected parts. The same treatment applies with equal satisfaction in those obscure painful conditions of the chest wall in the intercostal spaces so often met with in the class of patients now enrolled under that popular division called the neurasthenic. It is not for me to tell you just what it is that hurts those poor, nervous creatures, but it is only necessary to mention it to convey an idea to you of what is referred to.

It is not rheumatism, not is it essentially neuralgia, nor does it appear to be the same thing at all times. Certain it is, however, that the pain is increased by deep breathing, and is tender on pressure. The straps applied as in the other cases furnish the only means of immediate and permanent relief thus far at hand.

SURGICAL TREATMENT OF PUERPERAL PERITONITIS.

In an interesting article upon this subject (*Practice*, Richmond), Dr. W. E. B. Davis says:

Severe inflammations are usually made worse by pregnancy, and it is not an unusual thing where a women has suffered very much with pelvic pain during gestation, that she will have fever after delivery, which is due to an old salpingitis. Should there be pus in the tube, the tube is liable to be ruptured and the pus emptied into the abdominal cavity, causing a general peritonitis, unless an operation is done very promptly, and it is not usual for the symptoms to be clear enough to warrant the surgeon in operating in time to save life. Perhaps when more attention is given to this particular complication of pregnancy, the surgeon may be called in at any time when an operation will be decided upon earlier than has been the practice heretofore. Cases of general, puerperal peritonitis have been operated on by a number of surgeons, but the results

have been very unpromising. These cases offer but little from surgical procedures.

When quarts and gallons of pus are reported as having been removed from the general peritoneal cavity and recovery followed, I believe that the pus has usually resulted from a local collection, which has ruptured into the general cavity, and the operation has been done before sufficient time had elapsed for this amount of pus to result from the septic, inflammatory process in the general cavity.

As stated, localized peritonitis, with pus formation, is the form of the disease amenable to surgical treatment. I have operated on cases where there seemed to be no hope of recovery with favorable results. Have seen cases where the pulse was 135 get well after an operation for the relief of this condition.

Frequently a fever from puerperal infection may continue for weeks where there is no pus formation, and in which the ovaries are greatly enlarged and the broad ligament thickened with occlusion of the tubes. In one case the tissues were so soft that the ligatures would cut through, and it was necessary to take up the vessels and ligate them separately. An ovary in this condition is as septic as if it contained pus. Frequently the masses felt in the pelvis following delivery or abortion are due to pelvic peritonitis, with adhesions to the intestine and omentum, and when an operation is made to evacuate pus, there will often be found, in the place of pus, this condition present, but where fever is kept up, and the patient's condition shows sepsis, it is wiser to open the abdomen, break up these adhesions and remove the diseased appendages, which are keeping up the infection.

TO KEEP THE MOUTH SWEET.

The best and safest basis for any tooth powder is prepared chalk and charcoal, one to three, the charcoal always to be kept tightly shut from the action of the air. Where there is bleeding of the gums, a little borax may be added; where there is foulness, some cinnamon bark; where whitening is desired, some common salt. If a little rouge is added to disguise any portion of the powder not rinsed away, it is permissible; but it is better to make the rinsing thorough. Where the teeth are inclined to be loose in their settings, a wash of the tincture of myrrh is efficacious in fixing them more firmly. Many add to their pure chalk and charcoal a trifle of powdered castile soap as a detergent, with camphor for sweetening the breath where there is decay; it being remembered, however, that camphor can only be reduced to powder by grinding it with a pestle after being lightly sprinkled with rectified spirits of wine. Meanwhile, without taking so much trouble, some pulverized orris root, where the teeth are not decaying, will usually make the breath as sweet as the violets whose scent it imitates. A very pleasant and useful wash, where there are tender gums, is made by putting half an ounce of dried rose leaves to steep in a gill of boiling water, pressed and strained after three hours, and added to about six ounces of clarified honey, and evaporated for a few hours. This added, when used, to half as much water, makes a valuable astringent wash and gargle. An excellent deodorizer is made by taking equal portions of ground coffee, chocolate and white sugar, with two-thirds as much pulverized charcoal and vanilla, added to just enough dissolved gum tragacanth to make a stiff gum; bits of this kept in the mouth are said to make a bad breath pleasant.

Another breath-sweetener may be made at home by taking an ounce of extract liquorice as thick as paste, a third as much powdered catechu, the same of powdered sugar, a sixth as much gum-tragacanth, a third of a fluid drachm of

oil of cloves, half as much oil of cassia, and three drops each of oil of nutmeg and essence of ambergris, mixing well together, adding a trifle of rose-water and rolling the whole into tiny globules between the thumb and finger. Then if the little globules are laid on a leaf of silver, and another leaf is placed over them, the whole covered with a half sheet of paper, and rolled lightly beneath the flat open palm for half a minute, as fine and sweet silvered cachous will be the result as can be furnished by the best pharmacist. Take it all in all, care of the teeth *pays*, in comfort, in beauty, in the conservation of health from youth to old age. —*Harper's Weekly.*—*Ex.*

THE CRUDE MASSAGE (OR "MALLAISE") OF THE NATIVES OF INDIA.

Even fevers, rheumatism, malnutrition, the pains of child-birth, sleeplessness, and many ailments akin to these mentioned, are treated by the mallaise. The wealthy merchant or native prince has what he considers an indispensible adjunct to his corps of household servants in the person of a middle-aged woman who is skilful in applying this crude massage. She sits cross-legged on the floor by the side of the mat or soft Persian rug, upon which her patient reclines. Beginning with the extremities she rolls, kneads, presses, beats softly with her finger tips, or applies continued deep pressure to every portion of the body.

To the fever patient this deep pressure is of the greatest comfort, so that she often continues her almost superhuman efforts for many hours at one time.

This "Ayah," (nurse) is also apt to be gifted in romancing while she works, weaving fanciful tales of adventure or love, thus diverting the patients' thoughts from themselves. In monotonous tone of voice she spins these stories out hour after hour, till we are confident this was the origin of some of the stories of the Arabian nights, evidently of Persian and Indian origin—their endless adventure, their fanciful endings. To-day we find this ayah as of old reciting those wondrous tales, while the cocoanut oil lamp burns dimly in the corridors and arches of those Persian and Indian zananas. She gives the mallaise and weaves those stories, robbing weary aching bodies of their pains by her magic skill.

In the case of the lower class who are unable to obtain so skilful a manipulator, means of a still ruder type are resorted to for relief. Where the dreaded malarious fever causes every bone in the body to ache with the intensity of a toothache, the poor patient so craves the rudest approach to the mallaise! In his dire need, perhaps a friendly neighbor may come to his relief. While the poor patient lies on the ground with face downward, his friend walks with bare feet slowly up and down with measured tread the back and limbs of the naked patient till every blood vessel, however minute, has been emptied of his heated contents. Every nerve stretched to its utmost capacity. Every bone made to rub its fellow, and every limb move in its socket. The patient declares he is much relieved. In fact, many poor creatures use only this treatment for the frequent attacks of fever they contract from the foul air of their dense jungles.—Dr. Condict, *N. Y. Jour. Gynæc. and Obstet.*

SENSITIVE TEETH.

In the *American Journal of Dental Surgery*, for July, there is one of an interesting series of articles by Dr. Briggs, originally published in the *International Dental Journal*, treating of "Causes of Pain Referred to the Teeth." We extract a few paragraphs:

One writer says: "In very rare instances an apparently sound and healthy tooth will become the seat of severe and continuous pain, which, for the time,

resists amelioration from the application of any of the remedies usually employed. Generally, however, such a tooth, if the intensity of the pain does not necessitate its removal, will be found within a limited time to be responsive to local irritants, such as sweet, sour, hot, or cold articles, when brought into contact with some circumscribed part upon the crown, the response manifesting itself as acute but temporary pain. The cause of this morbid condition is but imperfectly understood, and its pathological significance is only fully appreciated when the sensitive surface yields to some destructive agent, resulting in molecular disintegration or caries." Such a spot upon the crown of a tooth must, as this author says, be very rare; but it is by no means uncommon for spots upon the roots of teeth, where there has been more or less recession of the gums, to become thus sensitive, and responsive to a painful degree to the sort of irritation just mentioned. Especially is this liable to occur when the relation of adjoining teeth is such that food is allowed to crowd up between the teeth, where, by its macerating effect and by the action of the acids formed in its fermentation, it brings about this hypersensitiveness of the surface. That this is the cause is proven by the fact that the sensitiveness disappears when, owing to the presence of approximal cavities, it is possible so to contour the teeth that food should not be wedged up between them. Pain due to this cause is pretty definitely located by the patient, and responds to the point of the examining instrument. That there is no depression or roughness of the surface shows that the condition is not the one next to be mentioned.

A HINT IN TREATING ASTHMA.

In almost all cases of asthma of confirmed character, our failure to relieve can be traced to a neglect of the condition of the heart. Your patient is a chronic one; you have treated him for the same thing for years and years with varying success. At times, and for quite long intervals, perhaps improvement has been marked. You have not examined him carefully for a long time; his heart has been pumping with increased force half his life or more; flabbiness and incipient dilatation have taken place without your knowledge, following close upon compensatory hypertrophy, which, until failure came, never inconvenienced him; case is going bad; you increase your nauseating doses, your asthma specifics, etc. From bad to worse is reached, and on and on, until exhaustion comes and the sick one is no longer able to go around.

At this epoch, you are relieved of the case by the suggestion of some one in authority, and your neighbor, a friend over across the way, is called in. The case is new; a careful examination is had, and at once the condition of the heart is recognized. Digitalis and strychnia are given, and other indications of general failure are judiciously met, with little concern for the asthma directly. Patient rapidly returns to his normal state of health.

In the above, a very practical hint is given, and I hope that this suggestion may impress you as forcibly as the above case impressed me, and that you may escape the humiliation I endured, in the most practical way.—Dr. Brown, Hillsboro, Ohio, *Cincinnati Lancet-Clinic.*

VARICELLA AND HERPES

Professor Johann Bókai, superintendent of the Children's Hopital at Buda-Pesth, publishes in a Hungarian medical journal several cases of varicella which had occurred in his practice under peculiar circumstances. The first of these cases had been observed in the year 1888, when a child was attacked by chicken-pox. Ten days afterwards another child in the same family had exhibited all the symptoms

of herpes zoster. Professor Bókai saw a similar case in 1891. A woman suffered from herpes zoster, and twelve days after its appearance, her child of eight years had chicken-pox. A second case occurred in the same year. He diagnosed herpes frontalis in a young man, and fifteen days later chicken-pox in his sister, a little girl of thirteen. Professor Bókai communicated his observations to Professor Korányi and the latter very soon reported a similar observation. He had then in his ward a patient suffering from herpes of the thigh, and eight days after his admission a patient in the same ward, who had a splenic tumor, contracted chicken-pox. The suggestion is offered that an attack of chicken-pox, instead of exhibiting general eruption, may under certain circumstances have the latter so circumscribed as to form the ring peculiar to herpes zoster. Professor Bókai considers this explanation the more likely, as latterly epidemics of herpes have been observed, especially by Kaposi. Certain forms of this disease have been known to be highly contagious.—*Lancet.*

PHENYL HYDRAZIN TEST FOR SUGAR IN URINE.

Some years ago (*Med. News*, August 6, 1887) we gave a description of this test as we had seen it used by Ultzmann in Vienna with observations of our own upon it. We are glad to find that Dr. Riker confirms our results (*Med. and Surg. Reporter*, September 17, 1892) After quoting our description from the American edition of Hoffman and Ultzmann's Analysis of the urine 1889, he says:

In taking the proportions used above I found that considerable caution was necessary to obtain good crystals. Instead of using two to three volumes of the urine to one of the salts, I found that to be sure of obtaining the phenyl-glucosazon crystals, even when large quantities of sugar were present, you must be careful and add but little more of the solution to be tested than to cover the dry salts, for like many crystalline bodies, they will not form in an excess of water, even when the crystals are practically insoluble in water. Our application is as follows: Place in a test-tube equal volumes of phenyl-hydrazin salt and sodium acetate crystals, and add just a sufficient amount of the solution to be tested to nicely cover the phenyl-hydrazin and sodium acetate salts; heat gently to the boiling point and while heating agitate the mixture so that the phenyl-hydrazin is brought into intimate contact with the solution, otherwise it would rise to the surface and sides of the tube, and on continued heating would decompose. If over two per cent. of sugar is present in the solution, after heating half a minute and placing tube to one side for fifteen minutes, when if the test is carefully made, you will have almost a perfect mass of lemon-yellow crystals, forming in bundles or sheaves. These crystals can be studied under the microscope: a one-half per cent. sugar solution, after standing one hour, began to form fine spider-web-like crystals: on the addition of a few drops of acetic acid, the crystallization was hastened. A one and one-fourth sugar solution stood twenty-four hours before good crystals were obtained, showing from this that the time required for the appearance of the crystals depended directly upon the amount of sugar present. The crystals will melt at 204° C. They are only slightly soluble in water. The crystals in the mother liquor were found insoluble in $HC_2H_3O_2$, HCl, HNO_3, H_2SO_4, NH_4OH; with NaOH and on standing exposed to the air, the crystals were gradually decomposed, the solution taking on a deep cherry-red color. KOH manifested the same action only the color of the solution was a light orange-red. In finishing I would say: 1. Use concentrated solutions. 2. If crystals do not form within a half hour, at the ordinary temperature, cool the test-tube to the freezing point, add one or two minims of acetic acid, and allow to stand fifteen minutes longer, when if no crystals form, we may be safe in concluding

that we have less than one-half per cent. sugar present. Every sample of normal urine tested gave negative results.

We will be glad to mail reprints of our own article to any one desiring to read it, for we believe the method is a valuable one.—Ed.

CASE OF DISLOCATION AT THE ELBOW-JOINT.

The case herewith reported is rather unique, both as to the lesion itself and as to the speedy recovery, taking into consideration the gravity of the injury.

On the morning of May 10, 1892, I was called to see Esmerigildo Gonzalez, thirteen years old. About two hours previously he had, while on his way to school, climbed a guamúchil tree for fruit. Losing his hold, he had fallen about twenty feet, striking upon his left arm. On visiting him at the hovel that served as home, I found his arm wrapped in a dirty rag, the removal of which disclosed an upward and backward dislocation of both radius and ulna, a wound in the cutaneous structure in front of the joint, through which protruded for a distance of about two and a half inches the lower extremity of the humerus, including both of the condyles. The wound had apparently been caused by the transmission of the force of the blow through the osseous structures. The anterior, internal lateral and external lateral ligaments were ruptured, as also the biceps and brachialis anticus muscles close to their attachments. It was not possible to detect any fracture. There was also a simple dislocation at the radio-ulnar carpal articulation.

Administering chloroform, "saddle-bag" antisepsis was resorted to, and the reduction at the elbowwas effected in the following manner. The thumb of the left hand of the operator was placed against the lower extremity of the humerus, the fingers of the same hand being used to steady that bone, while the forarm was extended with the other hand and the humerus pushed upward and backward, both movements being effected at the same time. In this way the reduction was very speedily effected. The wound was dressed antiseptically. The reduction of the dislocation at the wrist was next effected and the arm was placed in the semi-flexed position, no splints being used on account of the extreme heat.

There was a little swelling of the ruptured muscles, but no inflammation of the joint and no appreciable rise of temperature. The wound was dressed daily for five days as a precautionary measure; then every third day with a solution of mercuric chloride and mercuric chloride gauze. There was no suppuration whatever. In twenty days the wound had healed, and soon after, all of the movements of the joint, with the exception of extreme flexion, were restored.—Dr. Merchant, *Med. News.*

GALVANISM FOR FIBROIDS.

After relating several cases in which he made use of this agent, Dr. T. M. Wright, of Troy, Ohio, states his conclusion (Cincinati *Lancet-Clinic*, September 17), as follows:

1. Electricity is capable of exciting absorption, and of entirely removing large myomata of the uterus.

2. There is a class of tumors were the fibrous structure far exceeds the muscular structure, in which electricity, applied without puncture, fails to reduce the size of the tumor.

3. Intercurrent, inflammatory disease interferes with the action of electricity on fibroids.

4. Electricity produces much more rapid reduction in size of fibroids when the current is strong—150 to 300 milliamperes.

5. A current of 200 milliamperes, positive internally, is capable of producing the death of the tissue, as was shown by Case III.

6. Electricity is a most elegant tonic, and rarely or never fails to benefit the patient's general health very much during the course of treatment of fibroids.

7. Electricity is capable of controlling the hæmorrhage due to fibroids far more perfectly than any other means at our command.

IRON SALT IN DIARRHŒA.

Dr. Stanwell writes thus to the *Lancet*, September, 17:

Some few months ago, while engaged in the study of Bunge's Physiological and Pathological Chemistry, as translated by the late Dr. Wooldridge, I was much struck by his theory of the action of iron in chlorosis. While thinking this over, though not in entire agreement with him, I was impressed by the idea that it was not only possible but probable that iron might have a decided action in many cases of diarrhœa, by combining, as bismuth does, with the sulphuretted hydrogen and alkaline sulphides, to form inert insoluble metallic sulphides, and so check the diarrhœa by removing secondary, if I may so call it, irritation. It did not appear to me to be necessary to give the astringent forms of iron, on the assumption that, whatever forms of iron are given, it is probable that in the stomach they are converted into the chlorides and ultimately in the bowels after various changes into sulphides. The salt I chose for chief use was the citrate of iron and ammonia, though in some cases I used Bland's pills. For some time now I have treated a large number of cases of infantile diarrhœa, in many cases apparently due to defective sanitation, of irritative diarrhœa, and some of tubercular diarrhœa by this means, and with almost unvarying success. The rapidity with which the offensive smell of the motions disappears has exceeded anything I had thought likely, and half-a-dozen of my cases have apparently been so successful that I feel justified in suggesting that others may have a like success. In two or three cases too early a stoppage of the treatment was followed by a return of an offensive diarrhœa, which was soon checked again by resuming it. In one case, in a woman, a very violent attack of four days' duration, with intense griping and copious, watery, very offensive evacuations at frequent intervals following the eating of food, which her husband said at the time was unfit for use, was relieved in twelve hours, and entirely removed in two days.

Another case which had motions of a distinctly typhoid fever character, but with no spots, in which I was watching the temperature, ended in the same favorable way. Children of three or four months old take without any inconvenience five grains of the salt every four or five hours; adults, up to thirty grains every two or three hours. While discussing the therapeutic possibilities of iron, the following, though not entirely connected with its use in the treatment of diarrhœa, seems worthy of note. The combination of the tincture of the perchloride of iron with the solution of muriate of morphia yields a green solution, I imagine, with the formation of apomorphine or some similar derivative. Be this what it may, I have seen from the combination more distinct and rapid relief to the cough and diarrhœa of phthisis than from the administration of the drugs separately.

EPITHELIAL PEARLS IN THE MOUTHS OF NEW-BORN CHILDREN.

In the *Medical News*, October 1, 1892, Dr. Henry J. Garrigues, of New York, describes an epidemic of sore mouth, occurring in the Maternity Hospital, which he believes to be due to injury or infection of the epithelial pearls found in the mouth of the fœtus and of the young infant. These epithelial

pearls are small white globular tumors, pin-head to millet seed in size, found congenitally, in number from 1 to 5, along the raphe of the palate, preferably at the junction of the hard and soft palate. They are imbedded in the mucous membrane of the mouth; have an almost cartilaginous outer surface; and occurred in 53 out of 57 infants examined by Dr. Garrigues. They were formerly called retention-cysts or milium, but are now known to be fœtal structures, formed by invagination of the epithelium. If let alone they disappear of themselves in healthy infants by the end of the second month of the extra-uterine life. If the mouth of the infant becomes contaminated by blood, liquor amnii, etc., or if the nurse mistakes the pearls for sprue and tries to rub them off, or even if she washes the child's mouth roughly, superficial ulcers are formed which may spread so as to occupy nearly whole of the soft palate, and may become inflamed, covered by a yellow film suggesting diphtheria.

The treatment of the ulcers (the pearls do not need treatment) is the same as for other ulcers of the mouth. The parts may be gently mopped with half or third strength peroxide of hydrogen solution; or with 10 grains of chlorate of potash to the ounce of water; or with a saturated solution of boric acid; or, best of all, mopped with water slightly acidulated by (dilute) acetic acid followed by painting with 1 drachm of borax to the ounce of glycerine.

SNAKE-BITE IN AUSTRALIA.

A London correrpondent of the *American Practitioner and News* writes:

At a recent Nottingham meeting an Australian medical man mentioned that the Australian natives in case of snake bites employ a very simple remedy which is uniformly effective. The process being as follows: A piece of human hair string, which is made up as strong and as fine as the best whipcord, is tied as tightly as possible three or four inches above the region of the bite, then a circle round the bite is cut with a sharp stone knife about an eighth of an inch deep and a quarter of an inch from the two fang punctures; when this is done native slits the largest vein below the bite so as to let as much blood as possible out of the limb below the string, and keeps a stream of water running on the limb just above the affected part, rubbing the limb down all the time as hard as possible. This rubbing is kept up for about twenty minutes, till every drop of blood seems to be got out of the wounded portion. Then the slit vein is stitched up with a piece of sharp thin wood, some dirt is dabbed on the wound, and the string undone.

TREATMENT OF CONVULSIONS BY COMPRESSION OF CAROTID.

Dr. Gordon Kelly contributes the following report to the *Lancet*:

Mrs. H., a married woman, aged sixty four, had been under my care for over two years, suffering from chronic rheumatism, renal troubles, etc. I had not seen her for some months previously. I rode off immediately, and on my arrival the patient in a fit which I was told had lasted one hour and a half. The pulse was full, respiration noisy and labored, and the muscles of her face and body were convulsed. I determined to try Dr. Roheim's treatment. Except for the force with which the carotid was beating, I found this comparatively easy to do, the woman being very thin. Within a few moments from placing my thumb on the artery the convulsions of the face and body began to cease, the respiration gradually became slower and deeper, and in about two minutes and a half she come out of the fit, looked around in a dazed way, and when I asked her if she was better, nodded her head in reply. Since then she has had no return of the attack.

EXTIRPATION OF CANCER OF THE STOMACH.

Defontaine (*Arch. Prov. de Chir.*, July, 1892) reports the following case. The patient was a woman, aged 34, who commenced to suffer from stomach troubles in October, 1891. She first had attacks of flatulent dyspepsia and pain in the stomach at various times. In January, 1892, attacks of vomiting came on. They were not frequent, but were violent, and much material was ejected. These at first consisted of food, but lately the vomit has been of a chocolate color. This patient was seen on April 15, 1892, when a tumor was discovered in the left side of the abdomen, and just above the umbilicus; it was rounded in shape, about the size of a kidney, and was perfectly movable: it could easily be moved from one side of the middle line to the other. A malignant tumor, probably in the wall of the stomach, and without important adhesions to neighboring structures, having been diagnosed, on May 1st, the patient was chloroformed, and an incision was made in the linea alba. On examining the abdominal cavity a tumor was felt on the left of the incision. It was globular in shape, smooth, about the size of an apple, its surface covered with injected blood vessels; and it was apparently situated in the wall of the stomach, since attached to its lower border there was the great omentum. Above, it was fixed to the anterior surface of gastro-hepatic omentum. This adhesion was easily separated, but as this part of the omentum felt a little indurated, it was divided into two parts, ligatured and removed. The tumor was then excised with scissors. The stomach was opened, and, the finger being used as a guide, the separation was effected about 1 centimetre from the margin of the tumor. The mucous membrane bled considerably, but this was stopped with pressure forceps. The tumor was then removed, and then, after the stoppage of hæmorrhage and washing out the stomach, the margins of the wound in the stomach walls were brought together and united with a double row of sutures. The deeper row was passed through the mucous membrane and submucous tissue, and sometimes through the muscular coat. The superficial row was applied after Lembert's method through the serous and subserous coats. After this was done, the skin incision was closed, and dressings of iodoform gauze applied. The operation occupied two hours and a half. The patient recovered, and on May 26th, was well, and increased in weight.—*Brit. Med. Jour.*

THE WHITE CORPUSCLES AS PROTECTORS OF THE BLOOD.

Werigo (*Annales de l' Institut Pasteur*, July, 1892), when examining under the microscope the blood of the rabbit which had received, some minutes before, an injection of several cubic centimetres of a culture of B. prodigiosus in the auricular vein, was surprised to find the blood almost destitute of leucocytes. He repeated the experiment, with the same result, and became convinced that the phenomenon was constant. In order to prove this, he made a series of experiments, in which he injected cultures of different microbes into the blood, counting the leucocytes before and afterwards. The main fact brought forward receives the following explanation:—The leucocytes disappear from the blood under the above-named circumstances, because, when they have engulfed the microbes injected (which they speedily do), they are arrested in the organs, especially in the liver, where they pass on the ingested material to the endothelial cells of the organ. The rapidity with which the microbes become enclosed in the leucocytes is most astonishing—it is far greater than we have been accustomed to suppose. It is not the leucocytes alone, however, which undertake the clearance of the microbes from the blood, for the cells of spleen pulp, and also the endothelial cells of the liver, take on direct phagocytic functions. The author's

researches also lead him to consider that the first event after the injection of any microbes, of whatever virulence, is their inclusion in cells.—*British Medical Journal.*

A VALUABLE REMEDY IN DERMATOLOGY.

In summing up an article contributed to the *Jour. Cutan. and Genito-Urin. Dis.*, October, 1892, Dr. Cutler says: After two years' experience with it, I concluded:

I. That we have in this combination of chloral, carbolic acid and tincture of iodine, in equal portions, a topical remedy of decided value for the treatment of certain affections of the skin.

II. That the combination of these agents produces better results, has a wider range of usefulness and possesses greater therapeutical advantages than are found in either of the remedies when employed alone.

III. That the physiological properties of this solution, upon which the therapeutical advantages of the remedy depend, are those of an antiseptic, antipuritic, antiparasitic, antiphlogistic, analgesic, anæsthetic, absorbent and counter-irritant nature.

IV. That the solution is a powerful agent, and should not be used indiscriminately or carelessly, as there is danger of producing severe dermatitis and constitutional poisoning.

V. That its chief therapeutical advantages are due to its penetrating action into the tissues of the skin, rapid destruction of all forms of micro-organisms, and its wonderful power in hastening the absorption of inflammatory products.

VI. That it is, therefore, especially serviceable in parasitic skin affections and in all forms of chronic skin diseases characterized by thickening and induration of the skin, accompanied by scaling and itching.

VII. That it changes the form of some skin diseases, substituting for the original disease an acute dermatitis, which responds rapidly to treatment.

Recommendations of Therapeutic Agents.

"Vinolia Soap" receives the highest award anywhere. It has been awarded the medal of the Sanitary Congress of Great Britain (September, 1892). This is the highest award in the world, it is not granted until after exhaustive analyses and investigation, and has never been conferred on any toilet soap before. Pure toilet soaps are so very rare at the present day, that it has become a question of great importance to the medical profession to adopt only such a brand as would bring about the best results, especially in the treatment of skin diseases. The above notice should offer a suggestion to those who are still in doubt.. Through the kindness of Messrs. Blondeau et Cie., we were recently the recipient of a liberal supply of samples of Vinolia Soap and preparations, and feel so grateful with the results attained that we are much pleased to recommend a trial to any of our readers who have not yet tested their merits. For further particulars and samples address Messrs. Blondeau et Cie at their American offices, 73 and 75 Watts Street, New York City.

Medical Items.

One of the features of the Chicago World's Fair will be a collective exhibition of German health resorts and watering places.

Dr. R. B. Morison, of Johns Hopkins Hospital, who was ill with typhoid fever at Narragansett Pier several months, has returned to the city fully recovered.

A little boy was trying to define the word "treasures." After some thought he suggested, "they are things that I put away in the closet to keep and mamma throws away."

Josie Kempe, the little small-pox patient who was sent to the quarantine hospital several days ago, is improving, and Dr. Heiskell, the quarantine physician, thinks she will recover.

It is satisfactory to learn that the Dominion Government has commenced to effect improvement in the various quarantine stations. In view of the lamentable experiences at New York, it is to be hoped that the improvements will be thorough and adequate.—*Maritime Med. News.*

A weaver in Accrington, England, put a turpentine stupe over his abdomen for the relief of a severe colic. It did not seem to burn as much as it ought, and he struck a match to see what was the reason. The match ignited the turpentine, and the man was burned to death.—*Med. Record.*

Ground has now been broken for the new Pasteur Institute in New York, which is to be erected at Ninety-seventh Street and Central Park, West. The building is to be of brick, five stories in height, and fire-proof. In addition to ample facilities for prevention inoculations against hydrophobia, there will also be a department for the treatment of nervous diseases.—*Chicago Med. Recorder.*

The annual meeting of the American Gynæcological Society in Brooklyn, last week, passed off agreeably and profitably. The next meeting will be held in Philadelphia, and Dr. Theophilus Parvin, of that city, is the president-elect. Dr. W. H. Parrish and Dr. W. H. Baker were chosen vice-presidents; Dr. H. C. Coe, secretary; Dr. M. D. Mann, treasurer; and Dr. A. P. Dudley, Dr. E. C. Dudley, Dr. B. B. Browne, and Dr. W. E. Ford, members of the council. The membership has now risen to ninety-one. Dr. Battey, of Georgia, and Dr. Cantani, of Naples, were elected to honorary fellowship.—*N. Y. Med. Jour.*

The Oregon State Board of Health has adopted a rule, reports the *Journal American Medical Association*, defining a medical institution in good standing to be one requiring three regular sessions of six months each, covering three years' time. A Dr. T. Barwood was rejected on the ground that the school from which he graduated does not have such a three years' course. He brought the case before the Circuit Court, which rendered a decision adverse to the power of the State Board to make such distinction. On appeal to the Supreme Court the decision was overruled and the authority of the State Board sustained.—*Ex.*

The treatment of alopecia areata is the object of interesting researches. Dr. Motyr treats such cases by subcutaneous injections of bichloride of mercury. He employs for this purpose a solution containing a centigram of bichloride in forty grams of distilled water—that is to say a solution of sublimate 1—4000. In little patches he makes one injection, two in medium sized plaques and four to five in large ones. He repeats them every four days and at the end of the fourth or fifth series of injections considered them cured. After a few minutes the injection occasions a dermic congestion which increases in a circular manner to the extent of five or six centimeters around the point of injection. Each injection consists of five or six drops of fluid. Dr. Barthélemy has used Dr. Motyr's treatment and claims to have obtained good results.—*Jour. Cutan. and Genito Urin. Diseases.*

The British Medical Association passed a resolution recently admitting women doctors to membership. The vote was on motion to expunge an article in the constitution providing that "no female shall be eligible for election as a member of the association." The mover of the resolution, Dr. Galton, said times had changed in the past twenty years, and whereas in 1878, when the article was adopted, there were only eight women doctors in Great Britain, there are now 135. He said the battle against women in the medical profession was over, and they should extend the hand of fellowship to the women. The resolution was carried by a large majority. The seconder of the resoulution wanted it amended to read in favor of the admission of more women into the profession. There are 130 women students in the London school this year. There are also two schools in Edinburgh, two in Glasgow and one in Dublin.

The *Buffalo Medical and Surgical Journal* reports that the medical colleges of that city were both opened on Monday, September 26th, for the sessions of 1892 and 1893. The Buffalo University began its term in the old college building, but it expects to have the new one in readiness for occupation during the Christmas season. The Niagara University starts with a promising increase in attendance, and renewed energy in its teaching faculty. The influence of the State Medical and Examining Board is to stimulate a greater thoroughness on the part of the medical colleges throughout the State with reference to the quality of their teaching, as well as to a surveillance over the equipment of their students at the entrance examination. This is as it should be, and serves to bring down the rejections by the State Board to the minimum.

The *United States Investor* has decided to offer $1,000 in prizes for essays of not more than one column each respecting American cities and towns. The following distinguished gentlemen have consented to act as judges to award these prizes: Hon. Henry Cabot Lodge, of Mass., Hon. Chas. F. Crisp, of Georgia, Hon. Julius C. Burrows, of Michigan. The prizes will be divided as follows: For the best essay respecting any American city or town, $500; for the second best essay respecting any American city or town, $300; for the third best essay respecting any American city or town, $200. Each essay is to deal with the merits of the city or town chosen as its subject, either as a desirable place of residence; as affording opportunities for investment; as a place of peculiar location; as a place of unusually rapid growth; as a place in which an unusually large amount of capital and labor is employed in any particular industry; as a place possessed of great undeveloped resources, such as water-power, coal and iron, etc., which is peculiar because it has long escaped attention; as a place of great historical interest; or as possessing any other claim to unique interest or special distinction. In awarding the prizes, the judges will consider the literary merits of the essays, as well as the merits of the town or city described. They will not, however, go outside of the essay itself for evidence that the town or city possesses any special interest. Any claims which even a well-known city may have to distinction within the intent upon which these prizes are offered must rest wholly upon what is said by the essayist within the space of the column allotted to him. This condition, together with the consideration of literary merits, will give the essayist an even chance. All the essays which are intended for competition should be marked as such and forwarded to either of the offices of the *United States Investor*, 19 Pearl Street, Boston; 335 Broadway, New York; 241 Chestnut Street, Philadelphia.

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CONTENTS

ORIGINAL ARTICLES.

Address Delivered at the Opening of the Session, College Physicians and Surgeons, Baltimore, Oct. 1st, 1892. By L. E. Neale, M. D. . 1123

First International Congress for Gynæcology and Obstetrics. By W. S. Gardner, M. D. . 1131

EDITORIAL.

The Semi-Annual Meeting of the Medical and Chirurgical Faculty. 1132

Our Weekly Chronicle. 1133

MEDICAL PROGRESS.

A Dermoid Cyst Containing a Heart.—Intestinal Bacilli.—Spontaneous Rupture of the Spleen. Periodical Intermenstrual Pain.—Identity of Syringo-Myelitis and Leprosy.—A Visit to the Cholera Wards at the Hospital Necker.—The "Black Death."—The Treatment of Insomnia. Hernia of Abdominal Cicatrix After Laparotomy.—Electricity in Prostatic Hypertrophy.—Epistaxis.—Therapy of Nitroglycerine. 1134

MEDICAL ITEMS. 1142

Original Articles.

ADDRESS

DELIVERED AT THE OPENING OF THE SESSION, COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE, OCTOBER 1st, 1892.

BY L. E. NEALE M. D., OF BALTIMORE.

Gentlemen of the Faculty and Students of the College: In extending the hearty welcome and cordial greetings so fitting to this occasion, I can not fail to appreciate that, in the honor of addressing you this evening, I have the means not only of introducing the now beginning session of 1892-3, but also of introducing myself, for to some I may be a stranger, and perhaps to not a few unknown. Indeed I apprehend this to be the essential reason why I am permitted such a high privilege.

I am particularly proud to welcome you this evening, as I now have the honor of opening the first three-years' graded course so recently adopted by this faculty, which I am sure will mark a most important, and I sincerely trust a most prosperous, epoch in the history of this already flourishing institution.

To this advanced movement I welcome and invite you all. It is usually customary for the master of the house to bid his guests welcome; in this case I can but keenly feel that the honor, although none the less appreciated, has fallen to a very humble servant, yet I assure you the welcome and greetings are none the

less hearty, none the less sincere; for there is a close bond of unity among us, not only the general bond of fellowship that unites all men in one family, but what perhaps is the nearer and dearer bond uniting those of our calling in the one profession viz., the desire for knowledge, the thirst for wisdom, the unrelenting and never-ending search for truth. What says the very opening declaration of the hoary aged Hippocratic oath?

"I swear by Apollo the physician and Æsculapius and Health and All Heal and all the Gods and Goddesses, that according to my ability and judgment I will keep this oath and stipulation, to reckon him who taught me this art equally dear as my parents, to share my substance with him and relieve his necessities if required!"

Yes, we are all closely linked together in the common yet ever-noblest cause of the good of our fellow man, and to this end we are all seekers after truth.

"The watch-word of the medical profession is Truth; that is the *summum bonum* of the doctor's life."

This to my mind is the greatest strength of our unity; a power which dispels the darkness of ignorance and superstition, sweeps away the impediments of fraud, deceit, theory, dogmatism and hypothesis, conquers time itself and lives far beyond the grave.

Can the enlightened civilization of this nineteenth century point with more pride to a better and a nobler effort of the human race; can the world at large boast of any who labor for this end with more faith, more zeal, more self-sacrifice and devotion than the medical profession?

This search for truth and its practical application to the good and welfare of our fellow-man, is not only the common ground on which we all must meet, but also the higher and the nobler goal that should elevate us beyond the realm of personal gain and struggle for existence.

It is indeed our *raison d'etre*, the very reaason why we should be proud of our profession, and exert our best faculties in this its true cause, interest, advancement and promotion. With us the present is especially the time of truthful tendencies and well may you, the class of 1892-3, rejoice in the advantages of this,

THE AGE IN WHICH WE LIVE.

To-day we stand upon the threshold of the most important discoveries the world has ever known. On the one hand we witness the receding shadow and darkness of ignorance, superstition, theory and dogmatism; on the other the briliant dawn of facts and truths absolute, convincing, positive. It is the age of the original worker, the original thinker, the pioneer, the man who exercises the intelligence that God has given him and fully utilizes the means so bounteously bestowed.

So vast are the possibilities before us, that I honestly believe every man who faithfully, truthfully and zealously practises medicine in any of its branches must find opportunity of adding some little to our knowledge, if not actualiy discovering what may be of inestimable advantage to the human race.

Let me exhort you not to be guilty of an indolent indisposition to original

thought and work, which, mind you, need not at all necessarily be scientific in character, for such indolence was perhaps the greatest hindrance to progressive medicine in the past. Upon such an occasion as this perhaps we may with some little advantage shade our mind's eye for a moment from the brilliancy of our present advance, to cast a brief retrospect into the dark ages of this past.

Such retrospects may encourage us to more zealous work in the future.

To devise ways and means for preventing or relieving the "ills that flesh is heir to" must have been one of the first considerations of our earliest parents, forced upon them indeed by the sternest necessity—the universal law of self-preservation.

Barbarous as they were, these appliances and observances must have been very crude.

For ages, like a divine retribution, the superstition of barbarism dulled the intellect in matters medical, shrouded in the darkest ignorance the plainest, the most important facts and utterly destroyed all originality.

Votive offerings and memorial tablets recording the disease and remedy of every case in the rudest manner, were perhaps the chief source of medical knowledge in the Æsculapian age. Hippocrates, the wise old man of Cos (born 460 years B. C.) may be regarded as the father of rational and especially of dogmatic medicine.

For ages anatomy was not studied, hence its allied branches, pathology and physiology, were practically unknown.

Rude surgery had from time immemorial been practised, but the science of therapeutics was veiled in darkest ignorance. Polypharmaceutical compounds were the natural outcome, and as an example might be cited the celebrated *theriac* of Andromachus, physician to Nero, containing the dried flesh of vipers with sixty other ingredients, which was for a long time religiously regarded as a panacea for all diseases.

After Hippocrates, Galen (born in Pergamos, A. D. 130) attained the greatest reputation in medicine and his teachings prevailed for more than twelve centuries. He was a man of unusual literary attainments and succeeded in harmonising the various medical facts and creeds of his time. He studied anatomy, but was permitted to dissect only animals, and in the marvellous structure of the body he very wisely thought to show the wisdom of God and the practical aid to our knowledge of disease. He still clung to the Hippocratic humoral theory, however, the pneumonic principal of vital spirits and other superstitious ideas. His ingenious subtlety for explaining the phenomena of disease was as marvellous as it was absurd. If directed in the proper channel of original research, what might not such a brain as Galen's have accomplished? His work on materia medica, although based upon the false theories and dogmatism of his day, was held as a standard treatise for more than fourteen hundred years.

After Galen's time the Byzantine school of medicine took up his teachings, and here among many other great names we notice that of the celebrated Grecian

obstetrician, Paul of Ægina, whose renown spread over the east and west down through the Middle Ages.

The surgical writings of Albucasis, taken essentially from the works of Paul, became the origin of European surgery in the Middle Ages.

From the fifth to the tenth century the intellectual thread in the history of medicine is almost entirely lost, as the art of healing was practised chiefly by the monks in monasteries and the writings of the authors partook rather of the encyclopædic character than that of original observation. Such was especially the style of the great school of Salerno from the sixth to the thirteenth century. Unfortunately there was but little original thought, few if any original workers, and as the study of human anatomy was not pursued, medicine declined. Even the introduction of Arabian medicine in the scholastic period about the middle of the eleventh century did not decidedly raise the standard of the art above the Hippocratic and Galenic era.

After the decline of medicine in the middle ages, the general revival of Greek throughout Europe improved this intellectual field as it practically did all the arts and sciences. On the one hand the sciences of botany, materia medica and therapeutics really originated about this time from a revival of the works of Dioscorides and other naturalists; on the other hand, the works of Vesalius of Padua on human anatomy, appearing as they did in the sixteenth century and paving the way to a clearer understanding of physiology and pathology and ultimately leading to the great discovery of the circulation of the blood by Harvey in 1628, practically records the birth of modern medicine. Malphigi followed in 1661 with the discovery of the microscope. New diseases were studied: Arnold de Boot in 1649 first described the prevalent disease of rickets; the first autopsy on a plague-stricken patient was made by Hodges, of London, in 1665; a treatise on consumption came from the pen of Bennet, in 1654; and a number of new remedies was discovered, especially the cinchona bark, which came to Spain in the year 1640. As the Hippocratic and Galenic humoral pathology and theory of vital spirits passed away, a host of others took their place. Among these might be mentioned the chemical theory of disease called "*acridites*," the theory of the three elements, spirit, sulphur and salt; the rational pharmaceutical theory; the systemic, materialistic, spiritualistic, pneumatic, animistic and phlogistic, *ad infinitum*. Perhaps it was chiefly the writings of the astute and original observers Sydenham and Locke, 1624-89, that placed the practice of medicine upon a practical, rational and really scientific basis.

Note the practical wisdom of this sentence occurring in a letter from Locke to Molyneux:

"You can not imagine how far a little observation carefully made by a man not tied up to the four humors (Galen), or to sal sulphur and mercury (Paracelsus), or to acid and alkali (Silvius and Willis) which have of late prevailed, will carry a man in the curing of diseases, though very stubborn and dangerous; and that, with very little and common things and almost no medicine at all."

So was the reform brought about over two hundred years ago, by such simple

observations and such plain and truthful teaching. A new departure from the usual line of observation however, was made by Sir Edward Jenner, of England, who opened up the grand field of preventive medicine by "the dangerous practice of inoculation," which was introduced in England in 1721. We can to-day only marvel at its possibilities, for in this connection it would seem that we now stand upon the very threshold of the most important practical discoveries the world has ever known. It is only fair to say, that among all the theories of the eighteenth century which these reforms had to combat none proved more obstinate and invincible than the homœopathic under Hahnemann (1753-1844). This man believed that all chronic diseases resulted from either psora (the itch), syphilis, or sycosis (a skin disease) and that "seven-eighths of all chronic diseases are produced by itch driven inward." He utterly discarded the *vis medicatrix naturæ* and substituted the fallacious and absurd principle of *similia similibus curantur*. Another eccentricity was his theory of potentiality, by which the strength of medicines was supposed to increase in proportion to their dilution by fiftieths even to the thirtieth dilution. "He was ridiculed by the profession and then appealed to the laity, thus prospering of old, even as now, a victim of professional prejudice."

Notwithstanding such unwholesome obstructions, the onward progress of positive knowledge was irresistible, for men were found on every hand with brains and sense to see and to recognize the truth. Witness the genius of Ambroise Paré and mark how a simple clinical observation led to a most important practical discovery. It is recorded of him that on one occasion in 1836, while serving as surgeon in the French army, his supply of burning oil (with which all wounds received from fire arms were dressed) became exhausted, but notwithstanding this fact his patient did much better than usual. This very soon led to the restriction of the use of the actual cautery and to the adoption of the ligature as a means of restraining hæmorrhage.

Countless numbers of original workers and seekers after truth sprung up on every side, aiding their own intellects by the search-lights of physical science to reveal the hidden mysteries of nature, discarding theory and abstract reasoning, ignoring dogmatism and using hypothesis as a means of research rather than as an ultimate conclusion."

We now live in the golden, positive, practical age of truth or that of rational empyricism.

We must know not only what we do, but how and why we do it. We must utilize the intelligence God has given us to observe, think and comprehend.

To day the bauble of theory, hypothesis, dogmatism, is readily pricked and collapsed by the pointed facts of truth, of experience, of rational empyricism. What is now accepted must stand the crucial test of experience, of truth, of art, of science, and must be weighed in the balance, not only of knowledge, but of actual wisdom. Mark the difference:

> "Knowledge and wisdom, far from being one,
> Have oftentimes no connection. Knowledge dwells
> In heads replete with thoughts of other men:
> Wisdom, in minds attentive to their own.

Knowledge is a rude, unprofitable mass:
The mere material with which wisdom builds,
Till smoothed and squared and fitted to its place,
Does but encumber whom it seems to enrich.
Knowledge is proud that he hath learned so much,
Wisdom is humble that he knows no more."

The limits of this brief address will permit only the mention of a few great men who stand forth as beacon-lights along the line of the progress of medicine. In France we may allude to Bichat's works on anatomy and their bearing on pathology or the science of disease; to Broussai's Medicine Physiologique; to Corvisart, the translator and introducer into France of Avenbrugger's work on percussion, to Reiné Theophile Hyacinthe Lænnec, the celebrated discoverer of auscultation, and the founder of physical diagnosis; to Chomel; to Louis, who established an exact science of medicine by the introduction of the numerical or statistical method, thus avoiding the fallacy of conclusions drawn from isolated cases; to Cruveillier, Andral, Brettoneau, the eloquent and popular teacher Trousseau and the present great scientist, Pasteur. England emblazoned her escutcheon with such names as Priestley, Cavendish, the Hunters, Willan, Sydenham, Stokes, Bright, Addison, Alison, Bell, Marshall Hall, Lister and Wells. Germany presented a Skoda, Rockitansky, Virchow (the great father of modern cellular pathology), Langenbeck, Billroth, Niemeyer, Nothnagle, Schroeder, Saenger, Freund, Leopold, Koch and a host of others who lead the world to-day in advanced, progressive medical knowledge.

Our own country has not been laggard in the onward march, for we can boast of such leaders as Agnew, Ashurst, Atlee, Baker, Bancroft, Barker, Davis, Emmett, Flint, Leidy, Loomis, McGuire, Parvin, Penrose, Piffard, Porter, Richardson, Reynolds, Sayre, Sims, Stille, Thomas and Vaughn. Indeed, so vast and extensive has the good work been and so rapidly has medicine progressed that specialism has long since become an absolute necessity, as no man could keep abreast of the times in all branches and departments. To-day our literature fairly teems with the writings of new and original workers and our lecture-halls resound with the voices of men whose teachings can never die.

In the advanced scientific and experimental as well as practical field of progressive medicine, who can estimate the incalculable advantages of antisepsis, bacteriology and applied organic chemistry? Who can tell the good that has been and doubtless will be accomplished, regardless of individual ideas and methods, by such men as Lister, Pasteur, Koch and Vaughn? To my mind we are now rubbing the mist of germs from our eyes and are just awakening to the dawn of the possibilities of advanced chemical pathology.

It would seem that the scientific chemist of to-day may soon teach us the most startling truths of which we little dreamed. As I have already said, we now probably stand upon the very threshold of the most practically important discoveries in this connection the world has ever known. Such is *the age in which we live!*

Now, why have I mentioned all these things to you on this occasion? Simply to stimulate your zeal and energy, to point to the possibilities that await you, the higher and nobler aim for which you are to work, and the excellent means here afforded to carry on such work, to which the faculty of this College may well point with just and laudable pride.

Look about you at the already accomplished facts and truths thus so briefly and candidly announced in our catalogue.

"The new and magnificent Baltimore City Hospital, with its 350 beds, in immediate juxta-position with the college building. A special and separate hospital for colored people.

The Maryland Lying-in Asylum, the oldest institution of the kind in this State and one of the first in the United States where students of medicine were taught practical midwifery. Bay View, the Baltimore City Almshouse, with its 2,000 beds (inclusive of the department for the insane) whose doors are open to the classes of the school. The dispensary of the College of Physicians and Surgeons, which furnishes treatment and medicines free of charge to over 30,000 patients a year.

The facilities of the school for teaching medicine have been greatly enhanced by the erection of a commodious and admirably appointed college building. Its fine lecture halls, its physiological, chemical and pathological laboratories, its equipment as to microscopes, electrical and other appliances, challenge comparison with any school of medicine in this country."

The regular winter session has been extended to six months' duration, the spring course actively prosecuted, the preliminary examinations conditionally required, the standard of final examinations decidedly raised and made to include both oral and written, both practical and theoretical methods, and the required period of study extended to three sessions in graded courses. Can you deny the importance of these things, how directly they concern us all here assembled, and indeed most directly the people at large among whom you are to practice the science and the art of medicine as you have been taught? Here in these halls and with these facilities we are all workers together, all seekers after truth. We do not ask you, as did the teachers of old, to accept our theories, to believe our views, but the great feature of this school, a feature, as far as I know, unsurpassed by any other medical school of the South and comparing very favorably with any in this country, is its advantages in practical teaching both in the laboratory and at the bed-side, where plain and enduring facts must tell.

After receiving the proper preliminary instruction, you are required to do the work yourselves as far as practicable. This applies to every department and perhaps to none more so than my own. In the name of all that is reasonable and just, if obstetrics is worth studying at all, it certainly must be worth studying practically, and this will be made an especial feature of the course in this college. Nowadays, obstetrics may be rightly considered an exact science and an applied art *par excellence*. Dogmatism, hypothesis and theory have lived their

day in ye olden times of midwifery; we have now to deal with facts and truths based upon the most enduring natural laws.

I can not overestimate the advantages of this system of practical teaching by clinics, by demonstrations, by laboratory work and actual attendance upon the sick both in and out of the hospital.

It means that you are in great measure to be your own instructors, to study for yourselves, to think for yourselves, to work for yourselves and not to tacitly occupy your own seats in these halls and have all this generously done for you.

It means, in fact, that we design you to become good, capable, practical, trustworthy physicans and not mere graduates of a medical college legally chartered to license your practice.

I sincerely trust that no man within the sound of my voice to-night may lay this soothing unction to his soul, that he is here merely to graduate, to eke through the course by some hook or by crook and ultimately crown his feeble efforts with his diploma. I say, I sincerely trust for your own sakes as well as ours, that such can be truthfully said of no student of this college. If so, let me warn him of the inevitable consequences of his error and candidly advise him, *Don't!*

Believe me, my friends, success in practice is much more difficult to procure than your diplomas and this can only be obtained by diligent, earnest and zealous work. We are all of us students and must so remain, for the man who neglects his opportunities in this respect, to observe, to study and to work for himself, certainly materially hinders his own progress and may become virtually lost in the pursuit of success.

"Let us, then, be up and doing,
With a heart for any fate;
Still achieving, still pursuing,
Learn to labor and to wait."

Indeed, this policy is actually necessitated by the general advance of the times.

What means the prolonged session, the graded three years' course, the preliminary examinations, the well-equipped laboratories and the practical instruction in all departments of this institution? What means, in fine, the establishment of our State Board of Examiners?

Does it not mean that public and professional safety and welfare actually demand such a policy, that in our ranks to-day from excess of quantity and lack of quality, the struggle for existence is becoming harder, the inevitable competition more pronounced, that the honest and the worthy must protect themselves from the dishonest and the unworthy, that the day for the uneducated, the untrained, the charlatan and the quack is passing away or at least their work is restricted? It means that to succeed we must work, practically, individually, zealously, that we must possess not only the knowledge of our forefathers, but must acquire the wisdom of this *the age in which we live.*

FIRST INTERNATIONAL CONGRESS FOR GYNÆCOLOGY AND OBSTETRICS.

BY WM. S. GARDNER, M. D.

The morning session (Brussels, September 16, 1892) of the Congress was taken up by the discussion of Dr. A. Martin's very exhaustive report on Extra-Uterine Pregnancy. The following are his conclusions:

I. The etiology of extra-uterine pregnancy remains to the present day veiled in the deepest obscurity. Certain hypotheses already advanced explain only isolated cases, in a manner which does not defy criticism. The question can not be settled until the physiology of impregnation is better understood.

II. Most frequently the ovum is implanted in the tube. Ovarian attachment is less rare than was recently supposed. Abdominal insertion of the ovum remains doubtful.

III. The diagnosis of ectopic gestation is a diagnosis of probability, except in cases where we can observe the development of the fetal sac outside the uterine cavity or the development of an intra-uterine decidua without any distinguishable chorion, or when we discover the fetus itself.

IV. The evolution of extra-uterine pregnancy rarely ends in retrograded metamorphosis (lithopædion mummification) without any intervening accident. As a rule, the death of the ovum occurs through hæmorrhage into the fetal sac or into the ovum itself. The blood escapes into the abdominal cavity either out of the ostium of the tube (so-called tubal abortion), or by rupture of the tube in its continuity into the peritoneal cavity or broad ligament.

The hæmorrhage only ceases in exceptional cases. In most instances death occurs either from anæmia, or from a peritonitis, the precise nature of which remains obscure.

V. Ectopic gestation should be reckoned always as a dangerous neoplasm and treated accordingly.

Cases of development to term are so rare, that to respect the interests of the child is to neglect totally those of the mother.

VI. Consequently it would appear that operative interference undertaken as soon as possible is the right course in all forms of ectopic gestation. The fetal sac should be extirpated if possible. The treatment by hypodermic injections of morphia cures very slowly. Treatment by electricity can not yet be rated at its true value, as hitherto recorded observations on this method are not above criticism."

The following statistics are of special interest:

Of 255 cases treated on the expectant plan, 36⅞ per cent. recovered and 63⅛ per cent. died.

Of 515 cases operated upon 76⅞ per cent. recovered and 23⅛ per cent. died.

One of his closing sentences is this—"I have 27 times operated when there was fresh hæmorrhage into the abdominal cavity; 21 of these recovered and 6 died; five times have I *not* operated; these five all went to the grave."

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BALTIMORE, OCTOBER 22, 1892.

Editorial.

THE SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY.

This important meeting will be held on the third Tuesday of November (the 15th) in Easton, Talbot County, Maryland. Dr. Thomas A. Ashby, 1125 Madison Avenue, and Dr. G. Lane Taneyhill, 1103 Madison Avenue, Baltimore, will receive the "titles" of papers to be read. Some have already been received, and it is expected that a very satisfactory programme will be presented. Persons who desire to make pharmaceutical or other exhibits must apply, through Dr. Ashby, to the Local Committee in Easton.

For the honor of medicine in our State it is to be hoped that many physicians from Baltimore and from the Western Shore will take a part in the meeting; it being taken for granted that sectional pride will bring out the physicians of every county of the Eastern Shore in full force.

The brethren from the oyster and mosquito regions (which are destined to become a great sanitary resort) will have to get up early and work hard if they would improve on the reception given to the visiting members at former semi-annual meetings.

Easton is a place well worth visiting; every intelligent Marylander ought to know its attractions.

The semi-annual meetings not only stimulate the local profession to show what it can do, but also afford pleasant opportunities for social acquaintance, and healthful breathing-spells to tired country practitioners and to city men whose lungs are deeply pigmented with the dust of "improvements."

The Dietetic and Hygienic Gazette reports that Dr. H. C. Coe, of New York, has within two weeks removed two living children by Cæsarean section. Both of the mothers made a safe recovery from the operation. It is said that Dr. Coe some time ago removed successfully the entire uterus in a case of rupture of the uterus during labor at full term. Dr. Coe is certainly to be congratulated on he excellent results indicated in these reports.

OUR WEEKLY CHRONICLE.

REVIEW OF THE SLANDER TRIAL.

The chief interest of public medicine has for some weeks centered in the medical trial for slander going on before the City Court, Judge Harlan presiding, between certain followers of Hahnemann's doctrines. The trial has now come to an end by the award of $18,000 damages to the plaintiff, Dr. Buck. The council for the defendants has appealed, on exceptions, to the Court of Appeals. It appeared in evidence that the plaintiff some years ago, soon after his arrival in Baltimore, sent to the homœopathic doctors of the city a circular in which he offered his services as a "homœopathic" surgeon, intimating in the same circular that homœopathy had in Baltimore hitherto been destitute of such surgery as could be favorably compared with that of the "regular" profession. Upon seeking, shortly after this, admission into the Homœopathic Medical Society, he met with very obstinate resistance from a number of persons in the society, among whom were the six defendants, one of whom had been under the impression that he had been furnishing first-class surgery before the plaintiff located here. The strife was very bitter, but the plaintiff became a member of the society.

Some time after this two citizens laid before certain members of the faction opposed to the plaintiff, charges of malpractice against him, in regard to an operation for alleged uterine fibroid on an adult lady, who died about a week after the operation. The six defendants thereupon presented to the board of censors of the society, and through it to the society, a paper signed by them, in which they charged the plaintiff, on the strength of the affidavits of the said citizens, with *malpractice*, and other offences touching the laws of the society. After hearing the plaintiff's defense, but without bringing him face to face with the said citizens who accused him, the Homœopathic Society expelled him, giving the impression that it had convicted him of malpractice. No suit was entered against him in the civil courts by the relatives of the deceased patient.

On the ground that his practice had been injured by this expulsion and that the six defendants were moved in their accusations by *malice* against him, the plaintiff brought suit for damages.

At the trial the evidence was limited by decision of the court to certain facts which were *before the minds of the defendants at the time when the accusation was made before the society;* the question on which the jury was asked to give a decision being not, *whether the plaintiff* actually did the operation correctly, but *what conclusions a careful unbiased man ought to have drawn* from the evidence before the defendants *at the time they brought the accusations*. Expert testimony in criticisms of the plaintiff's statements on the witness stand was therefore excluded. The exhibition of the uterus, which was alleged by the plaintiff to contain the tumor in its walls, and which had been excised whole at the post-mortem, was also forbidden, on the same grounds, although the defendants contended that there had never been any tumor.

However the case may be viewed by the Court of Appeals, it illustrates

very clearly certain points in regard to the expulsion of physicians from medical societies.

1st. The movement for expulsion ought if possible to be made by members who have not previously shown any personal hostility to the accused.

2nd. If the accused is believed to have made himself liable to prosecution before the civil courts, and has not been so prosecuted, it is very dangerous for the medical society to appear to usurp the functions of such a court. It should in such a case confine its attention to simple violation of *some particular rule* of the society *specified in the charges;* so that, if the matter becomes public, the public may have no very definite idea of the grounds of expulsion, but may view it as the result of some society dispute, of interest only to the profession.

3rd. Every step in the prosecution and trial before the society should be the subject of gravest consideration on the part of the prosecutors and other members who are present, who should confine their proceedings most carefully within the scope of the *written* laws of the society and the *written* charges brought against the accused. We would not assert that this was or was not done in the present instance; we would simply mention that its importance was made very evident during the trial.

Medical Progress.

A DERMOID CYST CONTAINING A HEART.

At the October meeting of the Academy of Medicine, Dr. J. A. Johnstone related (*Cincinnati Lancet-Clinic*, October 15,) a case of this nature, exhibiting the specimen. He said:

The object in reporting this case is to show something very unique, and something I have never found before in a dermoid cyst—the interior of this gives you a very well-formed attempt at the formation of a heart. My second reason for making the report is to show what nature will do towards saving the life of patients who have had accidents. This tumor existed for several years. The patient was an Irish girl aged about twenty-five years, and gave a very indefinite history. Along in July last she had an attack of pain in the abdomen, and she said it seemed as though she was going to die right away, but it all passed off. However, when I came to do the operation, the cause of the pain was very apparent. The axis had been rotated upon itself almost twice and a half. The axis being the round ligament, this had been enough to excite a very marked peritonitis. The tumor was adherent, tremendously large vessels passing into it. The tumor was slate-colored at the time of the operation.

This attempt at the formation of a heart is something of which I never knew. There is a case recorded where an eye was pretty well formed, the cornea being well shown. Gray matter of the brain has been found, and, in fact, all portions of the hypoblast and mesoblast have been found. I am led to believe that the simple variation of the cyst is the fault of the Graafian follicle, but the formation of the dermoid is due to the ovum, which is retained, and in some way or other produces this formation.

The patient recovered.

INTESTINAL BACILLI.

The bacilli found in the intestines have from time to time given rise to a good deal of controversy, and so far as appearances go there is every probability that

the paper warfare will continue just as briskly as it has done in the past. In all the earlier literature concerning the bacillus coli communis this organism was spoken of as a simple saprophyte, but certain observers who maintained that it was not identical with Eberth's typhoid bacillus eventually suggested that it might be a cause of cholera nostras. Latterly a number of observers, amongst whom must now be reckoned Dr. Gabriel Vallet, have come to the conclusion that these two organisms are really identical. Of course there are certain facts which tend to strongly support this thesis, although it must be confessed that, for the present at any rate, it is better to keep an open mind on the subject. However, the following facts may be cited in favor of Dr. Vallet's position.

At first a considerable number of observations on typhogenous water were made, as a result of which it was stated that the typhoid bacillus was invariably found; but since investigators have come to recognize certain distinctive characters in the two organisms the bacillus coli communis is now described as occurring in typhogenous water much more frequently than is Eberth's typhoid bacillus; then, again, from careful bacteriological examination of typhoid stools it has been ascertained that the bacillus coli communis is found therein much more frequently than the typhoid bacillus itself, which is, indeed, comparatively rarely met with. After a careful morphological and biological investigation, taking the above facts into consideration, Dr. Vallet has come to the conclusion that the bacillus coli communis of Escherich is nothing more than a transition stage of Eberth's typhoid bacillus, and that there are, in fact, just as Loeffler, Roux, Yersin, Klein, and others have described in diphtheria, two forms of the same organism—a pathogenic and non-pathogenic. Some of the distinct characters are most important and those who hold that organisms may become markedly modified as they grow under very different conditions will find considerable evidence in support of their position in these observations. The bacillus coli communis may be cultivated, and will remain for a considerable length of time in liquid taken from privies and water closets and then sterilized: whilst the typhoid bacillus, when placed under similar conditions, not only ceases to multiply, but dies out—in from one to two weeks. Acting on the idea suggested by this experiment, Dr. Vallet found that when the bacillus coli communis is cultivated in fæcal solutions it becomes much more violent, sometimes even more so than the ordinary typhoid bacillus; and he points out, therefore, how important it is to prevent fermentation of fæcal matter. He maintains, indeed, that Murchison was perfectly correct in his statment that typhoid fever can arise quite independently of an anterior cause, by fermentation of this fæcal matter. He also insists upon the important part played by malnutrition and exhaustion in the etiology of typhoid fever, holding, as he does, that it is only when the tissues are exhausted and the secreting surfaces are acting irregularly or imperfectly that any of these forms of the bacillus can exert any pathogenic effect. The article is exceedingly interesting and some forcible arguments are advanced, but we cannot agree that Dr. Vallet has by any means proved his position to be invulnerable. —*Lancet.*

SPONTANEOUS RUPTURE OF THE SPLEEN.

Bowie (*Lancet*, No. 3603, p. 659) has reported the case of a tall, strong, finely-built cavalry soldier, thirty years old, in Africa, who, having a morbid dread of African fever, determined to return to his home in Scotland. He had had several attacks of fever, and was again seized. The patient was exceedingly anxious about himself, and suffered much from fear. The spleen was slightly enlarged. Following a chill and before the hot stage set in, the man complained of severe pain, which he referred to his heart. The patient failed to sleep during

the night. Retching was constant, a little greenish-yellow fluid being occasionally brought up. In addition to the pain referred to the heart, there was also pain in the loins and an inability to pass urine, notwithstanding a desire to do so. The bowels had been moved twice, the stools consisting of a little dark-colored fluid. The expression was anxious, the face dirty-gray, the features somewhat pinched, the lips livid and pale, the eyes clear and the pupils dilated. The patient complained of intense thirst. There was pain in both hypochondria. The pulse could be felt, but not counted; the heart-sounds were faint and indistinct. The abdomen was tense above the umbilicus, but below it was soft and could be manipulated without pain. Pressure in the hypochondria elicited pain, in the greater degree upon the left. By means of the catheter an ounce of dark-yellow, slightly turbid urine was withdrawn from the bladder; chemical tests disclosed the presence of albumin. Under stimulation the patient rallied slightly, but death finally set in. When the abdomen was opened, a large mass of liquid fluid and clotted blood was brought to view. This had evidently been poured out from the spleen, the capsule of which was found to be ruptured, although the organ was scarcely larger than normal.—*Medical News.*

PERIODICAL INTERMENSTRUAL PAIN.

In an article upon this subject (*Amer. Jour. Obstetrics*, October), Dr. Chauncey D. Palmer, of Cincinnati, Ohio, draws the following conclusions:

1. Periodical intermenstrual pain is a comparatively rare disease.
2. The disease is ovarian, not uterine.
3. This ovarian disease is an oöphoritis or peri-oöphoritis, or both.
4. The chief underlying exciting cause of these attacks of pain is the morbid obstruction to the extrusion of the contents of the Graafian follicles.
5. Many other morbid conditions, uterine, peri-uterine, or ovarian, may be associated with the oöphoritis or peri-oöphoritis, but their presence is not the cause of the essential symptoms.
6. Cure is effected only by overcoming the disease of the ovary or by its extirpation.

In regard to *treatment* he has found most benefit during the attack from the tincture of cannabis indica. Opiates he considers as objectionable here as in other forms of dysmenorrhœa. During the intervals reliance is to be placed on the most active so-called "alterative remedies:" mercuric bichloride, potassium iodide, ammonium chloride, and gold and sodium chloride, administered for a long time. The bromides are not to be ignored.

Local galvanization, with the anode to the vaginal vault, behind and to either side of the uterus, according to the ovary especially affected, occasionally changing to the secondary faradic current—the current of tension—has been of signal service to him.

Of course all manifest local disease, as well as errors of the general health, require attention, according to the kind and degree of the morbid complication. I have seen good results following topical applications of ichthyolated boroglyceride. Counter-irritation before and during the periodical attacks of pain is sometimes efficacious.

Kreuznach waters, in Germany, so efficacious in the cure of some female pelvic diseases, would appear especially useful in this disease. We all recognize that a change of climate and scenery, with rest and its diversion, and massage, do as much in many of these conditions as the mineral waters themselves.

Finally, after a failure of medicinal and hygienic measures, faithfully tried, oöphorectomy is clearly indicated in bad cases. While oöphorectomy has been

a greatly abused operation, particularly for many seeming reflex nervous diseases and for dysmenorrhœa, we are forced to accept the operation at times for this disease, but only as a last resort.

THE IDENTITY OF SYRINGO-MYELITIS AND LEPROSY.

Under this startling heading the *Lancet* of October 8th calls attention to an important paper which was recently read by Dr. Zambaco before the French Académie de Médecine on the identity of syringo-myelitis and leprosy. He had seen in Constantinople a considerable number of lepers, and became gradually convinced that the affection described as Morvan's disease, or syringo-myelitis, was no other than leprosy. He had also carefully studied the subject in Brittany, where syringo-myelitis had been first described, and where later on the disease was reported to occur frequently. He observed in all cases which were detained in hospital as incurable deformity of fingers and various other trophic changes, such as loss of one or more phalanges, muscular atrophy, anæsthesia or ulcerations, and all these symptoms he had previously observed in lepers. Photographs of a large number of these were shown which indicated a great resemblance between the two affections. Names of localities, such as *lambezeller—i. e.* "leper village"—and of cemeteries, bridges &c., which are still called *des lepreux*, testify to the fact that the disease has been endemic in Brittany since the earliest times. Old pictures of saints and fairies represent lepers just as they appear now. In a picture, for instance, of the miracles of St. Vincent, the saint is represented as restoring to a leper child its missing fingers. Dr. Zambaco believes that he as justified in concluding from stones, figures, and other objects found in many graves in Brittany that leprosy was imported into the country by the Phœnicians.

A VISIT TO THE CHOLERA WARDS AT THE HOSPITAL NECKER.

The Paris correspondent of the *Lancet* writes:

"A few days ago I spent an instructive hour amongst the cholera patients now under treatment in a special block of buildings situated in the grounds of the Necker Hospital. This service is directed by Professor Peter, who, by the way, is to occupy the chair at the approaching dinner of the Continental Anglo-American Medical Society, and I am bound to testify to the air of comfort reigning in the two wards of which the service is composed and to the devotion and cheerfulness of the very polite *personnel*. I found that twenty patients were actually under treatment, and I was informed that five fresh cases had been admitted during the last twenty-four hours, and that three had died during the same interval of time. The first case was admitted on June 7th, and since then 152 persons had been admitted. Of these, fifty (about a third) had died. None of the *personnel* had been attacked by the disease. It was curious to see in both wards—and very clean and airy they were, too—suffers of both sexes in adjacent beds. Almost all were doing well. One man only presented the ghastly *facies* peculiar to the disease. I refer more particularly to the sunken orbits, and his voice was still broken. Another man was vomiting. In the ward devoted to convalescents the occupants, the female portion of which was considerbly more aged than the male, were busily engaged in discussing with evident relish in most cases a meat lunch. The temperature of all the patients is taken regularly in the rectum. The lowest observed during the present epidemic was 78·8°F. (26° C.); after the death of the patient the temperature reached 39°C. (103°F.). Before I refer to the mode of temperature taking pursued I may mention that one of the nurses, who had served in cholera wards during the outbreak of 1884, told me that at that time the patients were invariably given an emetic as a pre-

liminary to other therapeutical measures. The treatment actually followed is as follows:—A patient admitted during the stage of collapse is at once vigorously rubbed with turpentine, hypodermic injections of caffeine and ether are given. The sufferer is then placed in a mustard bath at from 36°C. to 38°C., and kept in for about a quarter of an hour. Replaced in bed, a Chapman's spinal ice-bag is adjusted along the vertebral column. Directly the power of swallowing is regained a mixture composed of lactic acid, syrup and water is given and persevered with while the stools, which are regularly tested with litmus-paper, yield an alkaline reaction. The spinal ice-bag is renewed every two or three hours, its employment being continued until the kidneys resume their functions, this event being almost always synchronous with the cessation of the diarrhœa. A trial was being given to strychnine administered hypodermically in doses of one milligramme, but their experience of its effects have been too limited to allow them to judge of its merits. I interrogated the patients very closely on the effects of the spinal ice-bag. All, without exception, testified to the relief afforded by it, the cramps being arrested and a feeling of warmth being imparted. Asked if it appeared to exercise any beneficial influence on the vomiting and the diarrhœa, they were not so affirmative in their declarations. As a rule the patient begins to micturate in about thirty-six hours after admission, but only one woman attributed this effect to the use of the ice-bag. It must not be forgotten that ice *ad libitum* is given to suck, and that paregoric and champagne are prescribed against the diarrhœa and collapse respectively. My *confrère*, Dr. Chapman, whose enthusiasm for the ice-bag treatment is well known, assures me that better results would be obtained were the application of cold along the spine trusted to, to the exclusion of opium, which drug he condemns utterly in cholera therapeutics."

"THE BLACK DEATH."

A Berlin paper takes the following description from Russian papers:—"The Asiatic cholera and the plague are nothing compared with the terrible epidemic which has been scourging the population of Turkestan for some days past. A report of the Governor-General of Turkestan, which arrived at St. Petersburg on September 23rd, stated that "the Black Death," as the Tartars call the devastating epidemic, visited the district of Askabad, which had a population of 30,000, on September 10th, and swept away 1303 victims in six days. Against the Black Death, which has been known in Western Asia for a long time past, there is no remedy. Like a death-bringing poisonous desert wind it suddenly attacks whole regions, sweeps away man and beast, and then vanishes as swiftly as it came. It begins with violent ague fits, which last for about an hour, at intervals of five minutes, shaking the patient from head to foot. Then comes intolerable fever heat, the vessels swell, the pulse beats faster, the temperature keeps constantly rising. The patient is seized with convulsions and fainting fits and tortured with terrible pains. Suddenly the limbs become cold and rigid, the patient cannot move, and only utters from time to time a wailing sound that strikes all who hear it with horror. This second stage lasts only from fifteen to twenty minutes, and then, after a short intervals, during which heavy breathing is the only sign of life, death comes. Then large black plague boils cover the body and decomposition sets in in a few minutes."—*Lancet* Correspondent, October 4.

THE TREATMENT OF INSOMNIA.

Dr. Joseph Collins, of New York, in an interesting article on insomnia, published in the *Journal of Nervous and Mental Disease*, contrasts the action of

chloralamid and sulfonal in the the treatment of insomnia, and arrives at the following conclusions:

1. Chloralamid is a safe and one of the most reliable hypnotics.

2. It is not ordinarily followed by distressing after-symptoms, particularly headache.

3. It is especially valuable as a hypnotic where pain is a prominent factor, but not violent.

4. In cases of insomnia, where there is excessive activity of the brain, it is also useful.

5. On account of its stimulating activity on the respiratory function, it is the hypnotic *par excellence* in nervous exhaustion, associated with an asthenic condition of respiration and symptom complex indirectly dependent on this, brought about by defective oxidation and the formation of unstable chemical compounds in the system.

6. On account of its very slight action in depressing the circulation, it can be given in diseases associated with a weak heart, with greater safety than most of the other hypnotics, not excepting chloral itself.

7. It is conveniently administered in the shape of an elixir, and this overcomes the need of dissolving it.

8. Its dose is from one to three scruples, administered one hour before sleep is desired, and this should not be repeated within two hours, for occasionally the action of the drug is delayed.

Sulfonal is preferred when we wish to get very rapid action. It should be given dissolved in boiling water, taken as hot as possible. In this way it is at once absorbed, sleep frequently occuring in from fifteen to twenty minutes. The disadvantages of sulfonal are that the patient is liable to form the sulfonal habit, and that its effects last through part of the following day.—*Western Med. Rep.*

HERNIA OF ABDOMINAL CICATRIX AFTER LAPAROTOMY.

Goullioud (*Arch. de Tocol. et de Gynec.*, July and August, 1892) compares the ventral hernia of pregnancy and abdominal tumor with the troublesome hernia of the cicatrix after ovariotomy and other forms of abdominal section. In the first form, common amongst multiparæ, the linea alba is simply relaxed through excessive distension of the tissues which compose it. The aponeurotic layer of the abdominal walls remains entire, though thin, like the skin and peritoneum, from stretching. In hernia after operation, the protrusion is due to non-union of the aponeurotic layer of the linea alba. Hence Goullioud maintains that the aponeurotic layers of the abdominal incision should always be united by a special line of sutures. Three radical operations for the cure of hernia of the cicatrix are practised. Simon inverts all three layers and, making raw surfaces on the skin, unites them by suture. Maydl resects the entire sac and applies a special line of suture to each layer. In a third method the skin is resected, the other layers inverted, and their folded edges sutured, and lastly the edges of the skin-wound united by a separate line of suture. This operation, advocated by Chrobak, is more suited for ventral herniæ not due to operation. It has the advantage of avoiding the opening of the abdominal cavity. Complete resection, however, is as a rule preferable in hernia after ovariotomy, etc. The serous layer of the sac usually possesses secondary pouches, bands and omental adhesions. Their removal is clearly an advantage. Guilliond warns the surgeons of the difficulties of resection. The three layers are fused by tissue more or less dense. Hence free excision of the sac renders the operation less irksome,

and is also more advisable to the patient; the further the surgeon cuts from the limits of the cicatrix the easier will be the separation of the layers. When separated, after long and careful dissection, they must be sutured separately. The fibrous ring forming the neck of the sac often gives great trouble. The operation of resection is most likely to succeed when the recti are not overstretched; when, in fact, they still contract firmly. A perfect union of the aponeurotic layer is, of course, essential. Without such union the secondary operation will be followed by a yet larger hernial protrusion.—*British Medical Journal.*

ELECTRICITY IN PROSTATIC HYPERTROPHY.

In the *Medical and Surgical Reporter*, October 8, Dr. Massey, of Philadelphia, says:

Currents of from five to eighteen M.A., are useful in superficial prostatitis, but will not cure the hypertrophies. As in fibroids of the uterus, we must use from 20 to 70 M.A. This I have done frequently; the active pole (negative) being within the prostatic urethra, and the indifferent pad on the back. The only precautions used, in addition to scrupulous cleanliness of the electrode and gentleness in its insertion, being that the current was not permitted to remain at its strongest for more than a few seconds; as it was turned on and off at the controller in order to get the greatest constringing action with the least electrolytic irritation. If repeated not oftener than five days, no irritation will result, but rather a feeling of relief. In the intervals the same current strength is applied daily in the same manner through the rectal wall, the active electrode being an olive of proper size inserted into the rectum and pressed against the prostate, while the indifferent pad is on the abdomen. The primary faradic current should be used after the same method at each sitting, and I am inclined to look on it as an important adjuvant.

Under this treatment the shrinkage of the organ as a whole is soon manifest to the rectal touch, and as soon as a sufficient absorption of morbid products has occurred, with regression of interfering nodules and collars, the power and freedom of micturition will return.

During the progress of the curative treatment the catheter is passed as often as required, the instrument used for treatment serving the purpose of a catheter also at that sitting. Antiseptic flushing of the bladder is also not neglected at such intervals as the condition of the bladder demands.

A point of additional importance in the use of swelling currents of both varieties in prostatic disease is the fact that that the expulsive power of the bladder is always below par in these troubles, sometimes overshadowing the condition of the gland itself, and for this condition the treatment described is of great value.

The effect of this treatment is greatest in the symmetrical enlargement of the gland, as it is in this variety that the muscular substance is capable of greatest response. In fibroid nodules in one lobe of the prostate the older method of continuous application is possibly the best, or we may resort to electro-puncture, though this last resort is undesirable on account of the difficulty of maintaining asepsis.

The instrument shown you is made from a silver catheter with large curve, which has been insulated everywhere with fused hard rubber except a bare surface about two centimetres long just back of the eye. Besides having the advantage of serving as a catheter, and thus saving double instrumentation, the eye at the end serves to notify us of the exact position of the bare spot previous

to turning the current on. One of the chief advantages of this form of electrode is the ease with which it may be asepticised by heating in the flame of an alcohol lamp, the same heating permitting us also to repair any break that may have occurred in the thin hard-rubber coating of the instrument.

EPISTAXIS.

The cause of bleeding in a majority of cases is either traumatism, an erosion or a ulcerative process. Spurs or ecchondroses are often found growing from the septum. The apices become the seat of dry incrustations, causing a breach of continuity, from which bleeding is apt to occur.

Hæmorrhage is more frequently arterial than venous, as it more often occurs following the removal of ecchondroses, or exostosis. As to the best methods of dealing with hæmorrhage, the doctor urges first a thorough examination, and unless the bleeding is very profuse or the surface from which it comes is very large, he recommends the *galvano-cautery point*, which application should be thoroughly made. He has found this method most effective.

In the use of cocaine for performing small operations, there is a liability of hæmorrhage following, after the effects of the drug have passed off.

Irrigations with hot water, to which iodine has been added, in the proportion of 1 to 10,000, are very useful. Iodine, besides being slightly antiseptic, is hæmostatic.

Peroxide of hydrogen, a solution of antipyrin and aceto-tartrate of aluminum, are also useful in controlling hæmorrhage.

The use of perchloricle of iron is condemned. If these measures fail he resorts to plugging the nostrils, iodoform gauze being the best material, and a small soft rubber catheter the best instrument for placing it. If one nostril is plugged too tightly bleeding may occur from the other.—*Med. and Surg. Reporter.*

THERAPY OF NITROGLYCERINE.

In *Gaillard's Med. Jour.*, September, Dr. T. G. Stephens, while quoting the experience of other writers, speaks thus of his own observation upon the use of this drug:

In several cases of cardiac asthma from weakness of the heart's action, in aged people where there was a want of co-ordination of the right and left sides of the heart from senile degeneration, I have found nothing to give as immediate relief as nitroglycerine, seldom having to give more than one or two doses.

Scarlatina.—In the prodromal stage of scorlet fever, where there is great depression, patient feeble and suffers much from vomiting and chilliness, one or two doses of nitroglycerine adds much to the comfort of the patient and facilitates the *stadium eruptionis.*

Nitroglycerine in Hectic Fever.—During the last six months a case of advanced phthisis has fallen into my hands; a lady 34 years old. And the greatest suffering she experienced when I first saw her was the rigors which for a few weeks had been almost periodical. Happening to call on her when she was having a chill, I prescribed "trinitrin." In five minutes she felt better; in five more the chilliness had all vanished. She thought I was going to cure her. From that time on she has used the remedy with a marked degree of comfort.

During last summer I was called to see a lady 78 years old, residing in the country, who was suffering from chronic cardiac disease, dyspnœa and general dropsy—was completely water-logged; her feet and legs were enormously swollen and sloughing rapidly with constant oozing of serum and of unhealthy pus, and

the heart's activity very feeble. The drug had the effect of producing a notable change on the sloughing, with a slight relief in the oppressive breathing.

Medical Items.

Dr. H. Clinton McSherry returned last Tuesday from his four months' trip abroad. He spent most of his time in Germany.

Dr. Robert B. Morison has returned to his country home in "Long Green," Baltimore County after a four months' stay at Narragansett Pier. He will come to the city about November 1st.

When first tea was introduced into Europe, it was treated as a vegetable and boiled, and the "dish of tea" still remains among the old-fashioned phrases in literature, and is used by a few old-fashioned people.

The Canton free Dispensary has been opened for the treatment of eye, ear and throat diseases at Elliot and Hare Streets. Dr. Edward A. Bernstein is the surgeon in charge. The dispensary will be open daily at 2 P. M.

Dr. L. S. McMurtry, of Louisville, Ky., was unanimously elected President of the American Association of Obstetricians and Gynæcologists held at St. Louis, September 22nd. We congratulate the doctor, and are sure the Association could not make a better selection.

The "Dr. Hunter McGuire Prize," of one hundred dollars, for the best of the worthy essays presented on *Tetanus*, was awarded by the Committee on Examinations, after an ample opportunity to examine into the merits of those presented. The successful essay, by Dr. Chas. M. Blackford, Jr., is published in full in this issue.—*Va. Med. Mo.*

If you wish to remove a deciduous tooth and through fear the child will not permit it, slip a piece of rubber tubing over the crown down to the neck of the tooth, and in a few days the tooth will be so loose that it can be extracted with the fingers. This is given upon the authority of Dr. W. H. Eames, and is certainly worth trying.—*Dominion Dental Journal.—Ex.*

Dr. J. Percy Wade, assistant resident physician at Spring Grove Asylum, Catonsville, who is recovering from an attack of typhoid fever, has gone to Old Point Comfort, Va.

Salicylic acid is said to be an effectual remedy for tape-worm. It should be given in doses of eight grains every hour until forty grains have been taken, then follow with a full dose of castor oil.—*Va. Med. Monthly.*

In the University of Vienna, Otto Bergmeister has been elected Professor Extraordinary of Ophthalmology; Josef Englisch, Professor Extraordinary of Surgery; Ferdinand Hochstetter, Professor Extraordinary of Anatony; Alexander Kolisko and Richard Paltauf, Professors Extraordinary of Pathological Anatomy.—*Gaillards Medical Journal.*

On account of the retirement of Sir Joseph Lister from tha chair of Clinical Surgery at King's College Hospital, London, the professorship of Systematic Surgery, which has been held conjointly by Professor Rose and Professor Wat-

son Cheyne, is now occupied solely by Professor Cheyne, while Professor Rose has been appointed to the chair of Clinical Surgery.—*Ex.*

Dr. Wm. S. Gardner, to whom we are indebted for the excellent articles on foreign clinics and society meetings published this summer in the JOURNAL, has returned from Europe, and located at 613 Park Avenue, taking the offices occupied by the late Dr. Erich.

Students at the Universities of Paris, Vienna and Berlin number, respectively, 9,215, 6,220, and 5,527. In contrast with these there is a college in Sierra Leone which boasts of but twelve students and five professors. The total number of universities in the world, according to the *Minerve*, of Strassburg, is one hundred and forty-seven.

At the annual dinner given during the recent meeting of the British Medical Association at Nottingham, Dr. Withers Moore, President of the Council, announced that the council intended at no distant date to set aside the sum of fifty or sixty thousands pounds sterling for the purchase of a site and the erection of suitable buildings in London to serve as a permanent home for the Association.

The date of the regular meeting of the Clinical Society having fallen on October 21st, Columbus Day, a legal holiday, the meeting was postponed until Friday, November 4th. An excellent programme has been arranged—subject, "Cholera"—to be discussed by a number of prominent speakers. Every member is urged to be present. This meeting will also be of interest to many physicians who are not members of the Society. As the hall of the Society is large, there is no reason why such persons should not invite themselves to the meeting of November 4th.

The "family" system of treating lunatics which has been so successfully carried out in Belgium, at Gheel, and more recently at Lierneux, and also in Scotland and in the United States, has not till quite lately found favor in France. At the instigation of M. Charles Féré, however, the General Council of the Seine Department instituted in 1891 an inquiry on the subject. As the result of this inquiry the Council, at a meeting held on July 12th, adopted a report presented by M. Deschamps, in which a proposal was made that a first "family colony" of 100 patients suffering from senile dementia, and belonging exclusively to the category of harmless lunatics, shall be established at Dun-sur-Auron in the Cher Department.—*Ex.*

Baron Leon de Lenval, of Nice, offers a prize of 3,000 francs to the inventor of the best application of the principles of the microphone in the construction of a portable apparatus for the improvement of hearing in deaf patients. Instruments for competition should be sent to Professor Adam Politzer or Professor Victor V. Lang, Vienna, before December 31st, 1892. The prize will be awarded at the Fifth International Otological Congress to be held at Florence, in September, 1893. If no instrument is judged worthy of the prize, the jury reserve the right of announcing another competition, unless Baron de Lenval decides to otherwise dispose of the prize. The members of the jury are:—Professor Adam Politzer (president); and Professor Victor V. Lang, of Vienna; Dr. Benni, Warsaw; Dr. Gellé, Paris; Professor Urban Pritchard, London; Professor St. John Roosa, New York; and Professor Grazzi, of Florence.

A new disease has been brought to light through the researches of the gifted editor of the *Nat. Med. Rev.* He writes: In these days of bacterio-

logical research we must always be prepared for the most astonishing things. For instance, when we read of the great variety of germs found on an old dollar bill we almost fear to touch one should it ever chance to come within our reach. But it remains for a publishing house of a neighboring city to give to the profession the latest novelty in the form of disease. Printed in bold type on the wrapper, covering a most interesting book, we read: "If this book should miscarry." . . Oh! If it should! And right among such a promiscuous crowd as is usually congregated in a United States mail bag.

A practitioner in Chicago told me that in a labor case, after giving to the husband, who was acting as nurse, the usual order, "Let me know if everything is not right," he left. In the course of a few days, the nurse called on the doctor to ask if the foul odor could not be stopped. He said, "Did you use the syringe I gave you?" "Oh! yes, doctor, and although it does not affect the odor, it moves the bowels finely." Another case, which was under the care of a brother practitioner in the town in which I live: The doctor took the Davidson syringe, showed the intelligent (?) nurse how to use it in a basin of water, and left happy. Next day, not liking the appearance of the patient, he inquired, "Did you use the syringe?" "Yes, doctor, but the mixture you ordered was no sooner down, than it all came up again, and everything that had been eaten for a week." It is a fact that the nurse forced a pint of soap-suds down the patients' throat, by means of the syringe.—Dr. Caldwell, *Southern Med Record.*

The American Medical Temperance Association, through the kindness of J. H. Kellogg, M. D., of Battle Creek, Mich., offers the following prizes: 1. One hundred dollars for the best essay on the "Physical Action of Alcohol, Based on Original Research and Experiment." 2. One hundred dollars for the best essay on the "Non-Alcoholic Treatment of Disease." These essays must be sent to the Secretary of the Committee, Dr. Crothers, Hartford, Conn., on or before May 1, 1893. They should be in type writing, with the author's name in a sealed envelope, with motto to distinguish it. The report of the committee will be announced at the annual meeting at Milwaukee, Wis., in June, 1893, and the successful essay read. These essays will be the property of the Association, and will be published at the discretion of the committee. All essays are to be scientific and without restrictions as to length, and limited to physicians of this country. Address all inquiries to T. D. Crothers, M. D., Secretary of Committee, Hartford, Conn.

It is unfortunate that laws cannot be made sufficiently protective, or else executed so as to prohibit the sale of poisonous clothing to non-suspicious customers. The *Sanitary Era*, it seems, has been pointing out the dangers of recently introduced colored hose, as now worn by men and women in accordance with the demands of fashion, and has been collecting cases in proof of their dangers to life and health. This "progressive health journal—not for sanitarians only, but for citizens, mothers, nurses, invalids, everybody"—in its issue for September, 1892, adds the following "to the numerous poisonings from colored hose, heretofore reported:" "Schenectady, N. Y., September 2.—Ivan Kamitz, aged 31, died here yesterday. His death resulted from blood poisoning, caused by wearing colored hose on a foot which had blistered. In the middle of June, the Rev. Robert Doiz, pastor of the Reformed Church of Scotia, a suburb of this city, died from the same cause." If the histories of many cases of deaths from poisionous agents not recognized were properly traced, it is probable that many would be found as due to the wearing of colored hose or clothes—colored by poisonous dyes.—*Ex.*

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